STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The annual recertification survey and investigation of complaints #34380 and #34603 was conducted on September 22 through October 2, 2014, at Blount Memorial Transitional Care Center. The survey team identified Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) and Substandard Quality of Care related to a systemic problem with accurate transcription of medication orders into the electronic medication administration records and reconciliation of medication orders with the medication administration records during 24 hour chart checks. The facility's failure resulted in signficant medication errors for multiple residents. Deficiencies were cited from the investigation of Complaint #34603. An extended survey was conducted September 30-October 2, 2014. The facility was cited an Immediate Jeopardy at F157-L, F281-L, F309-L, F333-L, F425-L, F428-L, F490-L, F493-L, F501-L, and F520-L. The facility was cited Substandard Quality of Care at F309-L and F333-L. The Administrator, Medical Director, Chief Medical Officer/In House Legal Counsel, Chief Nursing Officer, and Director of Nursing were informed of the Immediate Jeopardy on September 30, 2014, at 4:00 p.m., in the conference room.	F 000	POC #2 Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the finding of the survey or the conclusions set forth in the Statement of Deficiencies. The facility offers its responses and Plan of Correction as a part of its ongoing efforts to provide quality care and patient safety, and as required under federal and state law. Accordingly, Blount Memorial TCC reserves the right to contest the survey findings and the conclusions that are set forth in the Statement of Deficiencies through informal dispute resolution, formal appeal proceedings, or any other administrative or legal proceedings that are available. The facility also reserves the right to modify its practices and procedures in the future as necessary to better meet the needs of its residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carie M Caldwell	Administrator	11/3/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 The Immediate Jeopardy was effective from February 12, 2014, through October 1, 2014. An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received on October 2, 2014, at 11:55 a.m., and corrective actions were validated onsite by the surveyors on October 2, 2014. Non-compliance of the Immediate Jeopardy tags continues at a scope and severity of a "F" level for monitoring of the effectiveness of corrective actions to ensure sustained compliance of monitoring processes by the Quality Assurance Committee.	F 000		
F 157 SS=L	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157	F157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents and/or family members of those found to be affected were notified of the specific medication error noted. Resident # 262 family members were notified on July 24, 2014. Resident # 457 wife was notified October 21, 2014 by RN, Risk Manager. Resident # 453 was notified October 21, 2014 by RN, Risk Manager. Resident # 452 was notified October 21, 2014 by RN, Risk Manager. Resident # 454 was notified October 22, 2014 by RN, Risk Manager. Resident # 279 was notified October 22, 2014 by RN, Risk Manager.	10/31/2014

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F 157	Continued From page 2 or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, interview, and review of facility investigation, the facility failed to notify the resident, resident's family, and/or physician of medication errors for fifteen residents (#262, #457, #188, #453, #452, #454, #455, #279, #111, #398, #105, #197, #23, #411, and #238) of twenty-four residents reviewed for medication errors, and failed to notify the physician of a significant weight loss for one resident (#388) of four residents reviewed for weight loss. The facility's failure to notify the resident, resident's family, and/or physician of medication errors placed the residents in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death). The facility's failure to develop and implement a plan of action to address the systemic failures was likely to place any resident who received medications at risk for Immediate Jeopardy. The facility's failure to ensure the physician was notified of a significant weight loss resulted in harm for resident #388.	F 157	Resident # 111 was notified October 21, 2014 by RN, Risk Manager. Resident # 398 was notified October 21, 2014 by RN, Risk Manager. Resident # 105 was notified October 21, 2014 by RN, Risk Manager. Resident # 197 was notified October 21, 2014 by RN, Risk Manager. In addition, her niece was notified by her request on October 24, 2014 Resident # 23 was notified October 21, 2014 by RN, Risk Manager. Resident # 411 wife was notified October 21, 2014 by RN, Risk Manager. Resident #238 was notified October 22, 2014 by RN, Risk Manager. Resident #455 has expired since discharge from the Transitional Care Center (TCC) (facility) on July 31, 2014. Therefore, notification of med error dated March 3 through 8, 2014, was deemed unnecessary and inappropriate. The Medical Director determined for resident #188, after her additional review of the medical record, the medication dispensing system reports, and pharmacy records, that the resident did not receive Coumadin as documented by the nurse. The nurse entry was inaccurate. This staff member no longer works at TCC (facility). In complete review of chart, there was NO order for Coumadin 2 mg to be given to the resident. However, an electronic request was sent to pharmacy for Coumadin 2 mg. Pharmacy rejected the order due to admission order clarification for "hold Coumadin". They notified TCC (facility) of rejection of the order. The pharmacy (which generates Coumadin orders per protocol) did not generate a Coumadin order for this patient. There was no Coumadin withdrawn from medication dispensing system profile assigned to this resident. Therefore, notification was not made to this resident and/or family.	

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F 157 Continued From page 3

The Administrator, Medical Director, Chief Medical Officer/In House Legal Counsel, Chief Nursing Officer, and Director of Nursing were informed of the Immediate Jeopardy on September 30, 2014, at 4:00 p.m., in the conference room.

The Immediate Jeopardy was effective February 12, 2014 through October 1, 2014.

An extended survey was conducted September 30 through October 2, 2014.

Acceptable Allegation of Compliance was received on October 2, 2014, and actions which removed the immediacy of the Jeopardy were verified on-site on October 2, 2014. Noncompliance continues at the severity of "F."

The findings included:

Review of facility policy, Change in a Patient's Condition or Status, last revised June 2012 revealed, "...1. Policy Statement: Our facility shall promptly notify the patient, his or her attending physician, and next-of-kin or representative (sponsor) of changes in the patient's condition and/or status...D. Regardless of the patient's mental or physical condition, nursing services will inform patients of any changes in their medical care or nursing treatments..."

Resident #262 was admitted to the facility on July 23, 2014 with diagnoses of Pneumonia, Acute Renal Failure, Rehabilitation, and Muscle Weakness.

Medical record review of the Medication Administration Record (MAR - record for

F 157 Resident #388's weight loss was reported to the Nurse Practitioner on September 23, 2014 by, Registered Dietician (RD). This was documented in the resident's medical record (see exhibit 1).

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

All residents in the TCC (facility) were considered to have the potential to be affected. On September 30, 2014 through October 1, 2014, charts and medication administration records (MARs) of 100% of the current residents (68) were reviewed during our conversion from electronic MAR to paper MAR. In the process, the records were analyzed for any medication errors by the Medical Director who was on site through the entire conversion process. Six additional errors were found by the Medical Director during this process. The Medical Director was found to be the attending physician for each of these residents, so notification of additional physicians was unnecessary.

The Director of Nursing notified each resident.

Our initial review identified 7 residents (8 errors) who we thought were affected. However, on further review, one resident (MR# 425745) had previously been notified of the error and another (one of two on MR# 448221) was found not to be an error. The following residents were affected:

Resident MR# 475365: Omission of medication on September 14, 2014. Resident was notified October 1, 2014 by the Director of Nursing.

Resident MR# 475365: Omission of medication on September 14, 2014. Resident was notified October 1, 2014 by the Director of Nursing.

Resident MR# 483234: Transcription error on September 18, 2014. Resident was notified October 1, 2014 by the Director of Nursing.

Resident MR# 689434: Transcription error on September 25, 2014. Resident was notified October 1, 2014 by the Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 4 documentation of medication administration) for July 2014 revealed on July 24, 2014, at 9:00 p.m., the resident was given Seroquel 200 mg (milligram) (an antipsychotic), Sertraline 25 mg (an antidepressant), Pravastatin 40 mg (anti-cholesterol), and Risperidone 0.5 mg (an antipsychotic). Medical record review of Physician's orders from July 23, 2014, (the resident's admission date) through July 25, 2014, (the date of the resident's discharge from the facility) revealed no orders for administration of Seroquel 200 mg, Sertraline 25 mg, Pravastatin 40 mg, or Risperidone 0.5 mg. Medical record review of a nurse's note dated July 25, 2014, revealed "...05:30 unit secretary found med [medication] error as...was putting in other orders on another pt [patient]. Pt. had 3 meds that were not [patient's] orders. VS [vital signs] B/P [blood pressure, normal blood pressure is 120/90]...Pt very sleepy hard to arouse...Physician notified, orders noted..." Review of a nurse's note dated July 25, 2014, revealed "...06:30 B/P 100/62...P 77...R 24...O2 sat 92%...slightly more arouseable respirations deeper regular will continue to observe..." Medical record review of a nurse's note date July 25, 2014, at 9:45 a.m., revealed the nurse started an intravenous access to administer fluids of normal saline at 60 ml/hr (milliliters per hour), as ordered by the physician, to treat hypotension (low blood pressure). Medical record review of the nurses note dated July 25, 2014, at 2:45 p.m. revealed, "...reported to [family members] medications given to pt last	F 157	Resident MR# 791005: Transcription error on September 23, 2014. Resident was notified October 1, 2014 by the Director of Nursing. Resident: MR# 524029: Transcription error on September 4, 2014. Resident was notified October 1, 2014 by the Director of Nursing. Resident MR# 448221: Transcription error on September 15, 2014. Resident was notified October 1, 2014 by the Director of Nursing. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; The "Change in a Resident's Condition or Status" policy (see exhibit 2) was a pre-existing policy that was reviewed, discussed, and revised October 22, 2014 by one of the Patient Care Coordinators (PCCs) with approval by the Interim Director of Nursing (DON), Chief Nursing Officer (CNO), and Medical Director. Revisions included instruction on how staff shall notify the resident and/or family, physician, and pharmacy of a change in status related to medication errors. "Medication Occurrence: Procedure for Reporting" policy (see exhibit 3) is a new policy that was created on October 22, 2014 by the Associate Nurse Executive of the parent hospital with approval by the Interim DON, Chief Medical Officer (CMO), CNO, and Medical Director. This policy includes a definition of a medication occurrence and detailed procedure for reporting medication occurrences. Educational in-service (see exhibit 4) on these policies was conducted by the Interim DON, Interim Clinical Educator (CE), and PCCs from October 22, 2014 – October 25, 2014, and included all Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nurse Assistants (CNAs) and Ward Clerks (WCs). Copies of the revised "Change in a Resident's Condition or Status" (see exhibit 2) and new policy "Medication Occurrence:	

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F 157	Continued From page 5 night. Pt family spoke with [NP - Nurse Practitioner] and [Clinical Educator/Quality Assurance Nurse - CE/QA], voiced concerns regarding medications. Requested pt be sent to ER [Emergency Room] for evaluation..." Medical record review of a facility Discharge Summary dated July 25, 2014, revealed "...Pt discharged to hospital, dx [diagnosis]: accidental overdose..." Interview with the Director of Nursing (DON) on September 23, 2014, at 3:40 p.m., in the DON's office, confirmed the resident's family had not been immediately notified of the medication error. The error had been discovered at 4:00 a.m., and the family was notified by the Quality Assurance Nurse at 2:45 p.m., over ten hours after the discovery of the medication error. Resident #457 was admitted to the facility on March 14, 2014, with diagnoses including Acute Venous Embolism and Thrombosis of Lower Extremity, and Fractured Hip. Medical record review of the Hospital Discharge Medication List dated March 14, 2014, revealed "...Enoxaparin [a medication to prolong blood clotting time, to prevent blood clots]...0.4 ml [milliliters], subcutaneous, every 24 hours..." Medical record review of the Physician's Recapitulation Orders dated March 14, 2014, revealed "...Enoxaparin...40 mg /0.4 ml sol [solution] give 0.4 ml...subcutaneous once a day for blood clotting control..." Medical record review of the Medication Record (MAR) dated March 14, 2014, through March 20,	F 157	Procedure for Reporting" (see exhibit 3) and information flyers were distributed and reviewed with the staff by the instructors during these educational sessions and staff questions were answered. All nursing staff members were educated by October 25, 2014 except for two staff members who were on vacation during this in-service and those two staff members completed their education to this policy by October 27, 2014 (see exhibit 5). These policies were in effect as of October 25, 2014. New or contract staff will receive education to these policies (see exhibits 2 and 3) as part of their new employee orientation packet. This educational material will be updated as policy changes occur by the CE. The CE will also be responsible for educating current RNs, LPNs, CNAs, and WCs of policy changes when they occur. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Medication occurrence reports (see exhibit 6) will be reviewed during Nursing Leadership Meeting. The Nursing Leadership Meetings began on October 7, 2014 and occur at 8:00am Monday through Friday and is attended by the TCC Administrator, DON, PCCs, CE, and Medical Director at her discretion or as requested. During this meeting, a general review of occurrences including medication errors and ensuring appropriate notification have been completed (see exhibit 7). Since it was created the CMO, CNO, and Medical Director have attended daily to ensure the Nursing Leadership Meeting is accomplishing its function. Medication occurrences from the weekend are reviewed on Monday mornings during the nursing leadership meetings. The medication occurrence report (see exhibit 6) indicates when the resident, family, pharmacy, and physician was notified and by whom. All deviations in proper notification will result in employee re-education and/or disciplinary action.	

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F 157	Continued From page 6 2014, revealed the days for administration of the medication was indicated as every other day and and the resident did not receive Enoxaparin 40 mg subcutaneous on March 15 and March 17, 2014. Medical record review of a Physician's Order dated March 18, 2014, revealed "...Vascular US [ultrasound] RLE [right lower extremity] Dx: [diagnosis] warmth, edema...Dx: chills, warm, swollen RLE..." Medical record review of a Diagnostic Report dated March 19, 2014, revealed "...Exam...Lower Venous Right...Clinical: RLE Edema and Warmth...Findings...Significant nonocclusive thrombus (blood clot) is seen within the right posterior tibial and peroneal veins...Impression: significant nonocclusive thrombus below the knee within the right peroneal and posterior tibial veins..." Medical record review of a Physician's Progress Note dated March 19, 2014, revealed "...results RLE doppler show nonocclusive thrombus [blood clot] below knee [within] right peroneal [and] post tibial veins. Pt has had erythema [redness]/edema x [times] 2 days..." Medical record review of a Physician's Order dated March 19, 2014, revealed "...lovenox [Enoxaparin] 1 mg/kg [kilogram] SQ [subcutaneous] every 12 hours pharmacy to assist with lovenox/coumadin bridge. Stop lovenox when INR (international normalized ratio) between 2-3...stop plavix...clarified with pharmacy to give lovenox 100 mg sq q [every] 12 hours...give additional 60 mg lovenox to equal to 100 mg lovenox today..."	F 157	All nursing staff will be in compliance with the policy "Medication Occurrences: Procedure for Reporting" (see exhibit 3) as evidenced by documentation of appropriate notifications on the medication occurrence form (see exhibit 6) by October 31, 2014. Documentation of notification is verified during daily Nursing Leadership Meetings.	

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F 157	Continued From page 7	F 157		

Review of the facility investigation dated March 20, 2014, revealed "...Error when entering order. clicked frequency options and entered every 2 days..."

Review of the facility investigation dated March 21, 2014, revealed "...Event Date: 3/14/2014...Order entry error off admission orders from [named hospital]. WC [ward clerk] changed the frequency of the med [medication] dosing which should not have been adjusted. Nurse did not notice the change in time frequencies...Medication involved: Enoxaparin [Lovenox]..."

Medical record review of the Anticoagulation Warfarin Orders dated March 21, 2014, revealed "...Continue Lovenox 100 mg SQ Q 12h, begin Warfarin 5 mg daily for new onset DVT [Deep Vein Thrombosis]..."

Medical record review of the Admission Minimum Data Set (MDS) dated March 27, 2014, revealed the resident was cognitively intact.

Interview with the CE/QA Nurse on September 29, 2014, at 8:30 a.m., in the conference room, confirmed the Lovenox order was transcribed incorrectly, entered as every other day, and the resident missed the dose on March 15 and 17, 2014. Continued interview confirmed the ward clerk entered the order incorrectly with the frequency of every other day.

Interview with Registered Nurse (RN) #6 on September 29, 2014, at 9:10 a.m., in the conference room, confirmed the RN was responsible for verifying the order of Lovenox and

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F 157	Continued From page 8	F 157		

failed to verify the order for accuracy. Continued interview confirmed the RN signed the twenty-four hour chart check on March 15, 2014, and did not identify the error.

Interview with NP #1 on September 29, 2014, at 11:00 a.m., in the conference room, confirmed it would be possible the missed doses contributed to the development of the DVT.

Interview with the Medical Director on September 29, 2014, at 2:40 p.m., in the conference room, confirmed "...always conceivable the resident developed the DVT due to two missed doses of Lovenox..."

Interview with the CE/QA Nurse on September 29, 2014, at 10:15 a.m., in the conference room, confirmed the error was identified on March 20, 2014. Further interview confirmed neither the patient nor family had been notified of the medication error.

Resident #188 was admitted to the facility on March 22, 2014, with diagnoses including Rehabilitation, Dislocated Shoulder, Intracranial Hemorrhage, Subdural Hematoma, and Atrial Fibrillation.

Medical record review of the admission orders dated March 22, 2014, revealed "...hold Coumadin for one month, until cleared by neurosurgery..."

Medical record review of the Medication Record dated March 25, 2014, revealed "...Coumadin 2 mg TAB [tablet] [Warfarin Sodium] Oral Every night @ [at] 6pm for Blood Clotting Control, stop date of March 26, 2014..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 9	F 157		

Medical record review of the Physician's Orders for March 25, 2014, revealed no order for Coumadin.

Medical record review of the MAR dated March 25, 2014, at 6:00 p.m., revealed LPN #2 administered a Coumadin 2 mg tablet to resident #188.

Medical record review of the Physician's Orders, dated March 26, 2014, revealed "dc [discontinue] Coumadin order."

Review of the facility investigation dated March 27, 2014, revealed "...no Coumadin order in chart. Pt only had Coumadin order for 3/25 - 3/26 but has been here since 3/22. RX [Pharmacy] status says it was ordered and canceled on 3/25 but still active 3/26..." Continued review revealed "...patient not aware of the medication error..."

Review of the facility investigation addendum (to the facility investigation dated March 27, 2014) revealed "...placed order in computer under wrong pt, so pharmacy called...canceled order..."

Interview with RN #7 Charge Nurse, on September 29, 2014, at 5:50 p.m., in the conference room, confirmed "...we are not required to notify the family with a med [medication] error..."

Interview with RN #3 Patient Care Coordinator (PCC) on September 30, 2014, at 8:25 a.m., in the conference room, confirmed the RN was responsible for the investigation of the administration of Coumadin for Resident #188. Continued interview confirmed "...residents and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 10	F 157		

families are not notified of medication errors..."

Interview with the CE/QA Nurse on September 30, 2014, at 8:56 a.m., in the conference room, confirmed the facility had failed to notify the family of Resident #188 of the medication error.

Resident #453 was admitted to the facility on February 10, 2014, with diagnoses including Rehabilitation, Aftercare for Healing Traumatic Hip Fracture, Muscle Weakness, and Spinal Stenosis.

Medical Record review of the Admission MDS dated February 23, 2014, revealed the resident scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact.

Medical record review of a physician's order dated February 12, 2014, revealed, "...Kcl [potassium] 20 meq [milliequivalent] po [by mouth] x [times] 1..."

Medical record review of the Medication Record dated February 10, 2014, through March 10, 2014, revealed the physician's order was transcribed to the Medication Record as "...Potassium Chloride 20 meq oral once a day at 0900 (9:00 a.m.) for abnormal labs..." Continued review of the Medication Record revealed the resident was administered Potassium 20 meq every day at 9:00 a.m., for a total of 22 days.

Review of a facility investigation signed and dated March 6, 2014, revealed, "...Was patient aware of medication error?..." Continued review of the investigation revealed the box marked "...No..." was checked.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 11	F 157		

Interview with the DON on September 25, 2014, at 11:36 a.m., in the conference room, confirmed the resident received 22 doses of potassium which were not ordered for the resident. Continued interview with the DON confirmed the resident was not notified of the medication error. Further interview confirmed the facility had failed to follow facility policy for notification.

Interview with the CE/QA Nurse on September 30, 2014, at 8:37 a.m., in the Classroom, confirmed the facility does not immediately notify residents or resident's family of medication errors. Continued interview confirmed the facility had failed to notify the resident of the medication error.

Interview with the Administrator on September 30, 2014, at 10:13 a.m., in the conference room, confirmed the facility policy does not specifically address medication errors, however the policy addressed resident notification related to any incident which might affect the resident. Continued interview confirmed the facility had failed to notify the resident of the medication error.

Resident #452 was admitted to the facility on January 24, 2014, with diagnoses including Intervertebral Disc Disorders, Thoracic Region, Urinary Tract Infection, Osteoarthrosis, Diabetes, and Hypertension.

Medical record review of the Admission MDS dated February 6, 2014, revealed the resident was cognitively intact.

Medical record review of the Physician's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 12 Recapitulation Orders dated January 24, 2014, revealed "...Percocet [brand name of Oxycodone, a narcotic pain reliever] 325 mg-5 mg tab...every 6 hours prn [as needed] for pain..." Medical record review of a Physician's Order dated January 24, 2014, revealed "...Order clarification Percocet 5/325 1 q [every] 6 [hours] prn for pain, may repeat in 1 [hour] if ineffective..." Medical record review of a Physician's Order dated January 27, 2014, revealed "...Hydrocodone [a narcotic pain reliever] 5/325 [milligrams] po Q 8 [hours] scheduled [and] Q 6 [hours] PRN pain..." Medical record review of a prescription dated January 27, 2014, revealed "...Oxycodone/APAP [a narcotic pain reliever] 5/325...1 tab po Q 6 [hours] PRN pain...1 tab po Q 8 [hours] schedule..." Medical record review of a Physician's Order dated January 31, 2014, revealed "...Discontinue Hydrocodone order [and] continue Oxycodone order per script..." Medical record review of the Medication Record dated January 24, 2014, through January 31, 2014, revealed "...1/27/14 Hydrocodone...325 mg-5 mg 1 tab...oral every 8 hours for pain..." Continued review revealed the resident received the Hydrocodone scheduled every eight hours from January 27, 2014 through January 30, 2014. Medical record review of the Medication Record dated January 24, 2014, through January 31, 2014, revealed "...Hydrocodone...325 mg-5 mg 1 tab...oral every 6 hours prn for pain..." Continued	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 13	F 157		

review revealed the resident received a total of five doses of the medication on January 27 and 28, 2014.

Medical record review of the Medication Record dated January 24, 2014, through January 31, 2014, revealed "...Percocet 325 mg-5 mg...oral every 6 hours prn for pain..." Continued review revealed the resident received a total of seven doses on January 24 - 28, 2014, and three doses on January 30, 2014.

Review of the facility investigation dated February 4, 2014, revealed "...Event Date: 1/27/2014...Wrong Medication...MD (Medical Doctor #2) wrote order in chart for Hydrocodone 5/325 mg Q 8 hr and Q 6 hr-prn. (Medical Doctor #2) wrote a prescription for Oxycodone 5/325 mg Q 8 hr and Q 6 hr-prn for the same patient on the date. Prescription was not signed off and not noted if it had been faxed to pharmacy. Pt. received both medications. Script omission not caught on 24 hour chart check and not by the Registered Nurse (RN) in charge..."

Interview with the CE/QA Nurse on September 25, 2014, at 10:30 a.m., in the conference room, confirmed the resident received the Oxycodone and Hydrocodone on January 27, 28, and 30th. Continued interview confirmed the nurse should have clarified the order and it was discovered on January 31, 2014, by chart check because the NP wrote an order to discontinue the Hydrocodone.

Telephone interview with the resident's physician on September 29, 2014, at 3:50 p.m., confirmed the physician did not intend for the resident to have both Percocet (Oxycodone) and Hydrocodone.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 14	F 157		

Telephone interview with RN #2 on September 30, 2014, at 8:20 a.m., confirmed when new orders were written, the RN verified the orders with the computer. Further interview confirmed the RN was not aware of the medication order for Hydrocodone and Oxycodone, two pain medications.

Interview with the CE/QA Nurse on September 30, 2014, at 8:37 a.m., in the Classroom, confirmed the facility does not immediately notify residents or residents' families of medication errors.

Resident #454 was admitted to the facility on February 6, 2014, with diagnoses including Rehabilitation, Osteoporosis, Backache, Difficulty Walking, and Anemia.

Medical record review of Admission MDS dated February 19, 2014, revealed the resident scored a 15 out of 15 on the BIMS indicating the resident was cognitively intact.

Medical record review of a Physician's Order dated February 27, 2014, revealed a medication order "...Cefdinir [an antibiotic] 300 mg PO q12 hours [every 12 hours] x 5 days..."

Medical record review of the Medication Record dated February 6, 2014, through March 6, 2014, revealed the order for the medication was entered to start on February 27, 2014, and entered with a stop date for March 6, 2014 (7 days later) instead of for March 4, 2014 (5 days later). Continued review revealed the resident received 5 extra doses of the antibiotic.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 15	F 157		

Review of a facility investigation signed and dated March 6, 2014, revealed, "...Was patient aware of medication error?..." Continued review of the facility investigation revealed the box marked "...No..." was checked.

Interview with the DON on September 30, 2014, at 12:40 p.m., in the conference room, confirmed the resident was not notified of the medication error, and confirmed the facility had failed to follow their policy regarding notification.

Resident #455 was admitted to the facility on February 24, 2014, with admitting diagnoses of Urinary Tract Infection, Pressure Ulcer lower Back, Osteoporosis, and Osteoarthritis.

Medical record review of a Physician's Order dated March 3, 2014, revealed an order for Prilosec 20 mg (an antacid) daily.

Medical record review of the Physician's Orders dated March 8, 2014, revealed the physician reordered the Prilosec 20 mg daily.

Medical record review of the resident's MAR for March 2014 revealed Prilosec was not administered from March 3 through March 8, 2014.

Review of a facility investigation dated March 13, 2014, revealed the order for Prilosec was not discovered by Licensed Practical Nurse (LPN) #9 or by RN #1 on the twenty-four hour chart check. Continued review revealed the resident's physician was notified at 1:00 p.m., on March 28 2014, twenty five days after the error.

Interview with the DON on September 30, 2014,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 16	F 157		

at 3:00 p.m., in the DON's office, confirmed the Physician had not been immediately notified and the family had not been notified of the medication error.

Resident #279 was admitted to the facility on April 5, 2014 with diagnoses of Rehabilitation, Aftercare for Healing Traumatic Fracture of Hip, Pneumonia, Urinary Tract Infection, and Diabetes Mellitus.

Medical record review of a physician's order dated April 10, 2014, revealed an order for Rocephin (an antibiotic) 1 Gram, IV (intravenous) now and daily for 7 days.

Medical record review of the resident's Medication Record for April, 2014, revealed the order had not been transcribed to the MAR. Continued review of the resident's MAR revealed the Rocephin had not been given from April 10 through April 13, 2014, and four doses had been missed.

Review of a facility investigation dated April 17, 2014, revealed the order for the Rocephin 1 gram IV had not been transcribed. Continued review revealed the cause of the error listed was the order was not processed.

Interview with the DON on September 30, 2014, at 3:00 p.m., in the DON's office, confirmed the family had not been notified of the medication error.

Resident #111 was admitted to the facility on July 21, 2014, with diagnoses including Rehabilitation, Traumatic Fracture of the Hip, Osteoporosis, and Difficulty Walking.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 17	F 157		

Medical record review of the facility admission records dated July 21, 2014, revealed "...Oxycodone 5 mg, 1 tab ORALLY, every 4 hours as needed, for 3 days, as needed, pain management..." Further review revealed a duplicate Oxycodone order from a prescription detail (prescription paper order for narcotics).

Medical record review of the Medication Record for July 2014, revealed "Oxycodone HCL oral every 4 hours prn for moderate pain." Continued review revealed the Oxycodone was given from July 25 through July 29, 2014, by four LPNs for five additional days and eleven additional doses after the date the medication was to be discontinued.

Medical record review of the 5 day MDS Assessment dated July 28, 2014, revealed a BIMS of 14 (10 and above, cognitively intact). Further review of the MDS revealed "...Preferences...very important to have your family involved in discussions about your care."

Review of the facility investigation dated July 29, 2014, revealed the event occurred on July 21, 2014, at 10:32 p.m., and "...medication was not discontinued after 3 days as ordered..." Continued review revealed Resident #111 continued to receive Oxycodone 5 mg for five additional days and eleven additional doses. Continued review revealed the patient was not notified of the medication error.

Interview with NP #1 on September 29, 2014, at 11:30 a.m., in the conference room, confirmed resident #111 was not notified of the medication error.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 18	F 157		

Interview with RN #3 PCC on September 30, 2014, at 8:25 a.m., in the conference room, confirmed "...residents and families are not notified of med errors..."

Interview with the DON on October 1, 2014, at 2:20 p.m., in the conference room, confirmed the facility failed to notify Resident #111 of receiving Oxycodone for five additional days and eleven additional doses after the discontinued date.

Resident #398 was admitted to the facility on July 21, 2014, with admitting diagnoses of Rehabilitation Process of Right total Knee replacement, Hypertension, Asthma, Difficulty in Walking, and Obstructive Sleep Apnea.

Medical record review of a physician's admission order dated July 21, 2014, revealed an order for Diazepam 5 mg (an antianxiety medication) twice a day as needed.

Medical record review of the MAR for July 21, 2014, through July 29, 2014, revealed Diazepam 5 mg was transcribed to be administered as a scheduled dose, twice per day, instead of as needed. Further review of the MAR revealed the medication had been administered two times per day from July 22 through July 28, 2014, and an additional dose was given on the morning of July 29, 2014. The resident had received fifteen doses of the medicine.

Review of a facility investigation dated July 29, 2014, revealed "...a copy of the report had been placed on clipboard by [LPN #11]. The medication order was for Diazepam 5 mg BID [twice daily] PRN [as needed]. The order was transcribed into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 19	F 157		

the computer as a routine scheduled order twice daily instead of as needed..."

Interview with the DON on September 30, 2014, at 3:00 p.m., in the DON's office, confirmed the resident and the family had not been notified of the medication error.

Resident #105 was admitted to the facility on July 10, 2014, with diagnoses including Rehabilitation, Acute Renal Failure, Hypertension, Hypopotassemia, and Diabetes Mellitus.

Medical record review of the 5 day MDS Assessment dated July 17, 2014, revealed a BIMS of 14 (10 and above cognitively intact).

Medical record review of the Physician's Orders dated July 10, 2014, revealed "Potassium Chloride [electrolyte replacement for low blood levels of potassium] Extended Release Tablet, 10 milliequivalent [meq] every day."

Medical record review of the Physician's Orders dated July 23, 2014, at 6:30 p.m., revealed "KCL 20 meq po q am [every morning] [start in am] x 3 days [edema]."

Medical record review of the MAR for July 2014 revealed the order for "Potassium Chloride 20 meq oral once a day" was dated for three days, July 24, 25, and 26, 2014. Further review revealed the Potassium Chloride 10 meq daily was not placed on hold and remained on the MAR.

Medical record review of the MAR revealed on July 24, 2014, LPN #10 administered the 20 meq Potassium Chloride tablet and the 10 meq

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 20 Potassium Chloride tablet for a total of 30 meq of Potassium Chloride. Medical record review of the Physician's Orders dated July 25, 2014, at 8:23 a.m., revealed "...kcl (potassium chloride) on hold until 7/27 due to increase in meds (medications)..." Review of the facility investigation dated August 14, 2014, revealed "...Pt already on KCL 10 meq daily, but new order for 20 meq x 3 days received. 10 meq not placed on hold so the pt received 30 meq on the first day of the three day order. Potassium level to be checked the next am [morning]. No harm noted. WC did not notice the 10 meq order needed to be placed on hold..." Further review revealed the patient was not notified of the medication error. Interview with the RN #7 Charge Nurse on September 29, 2014, at 5:50 p.m., in the conference room, confirmed "...we are not required to notify the family with a med [medication] error..." Interview with RN #3 PCC on September 30, 2014, at 8:25 a.m., in the conference room, confirmed "...residents and families are not notified of med errors..." Telephone interview with RN #5 on September 30, 2014, at 9:00 a.m., confirmed "...I don't notify families for med errors...you don't know if the med caused problems..." Resident #197 was admitted to the facility on July 24, 2014, with diagnoses of Trans Cerebral Ischemia, Esophageal Reflux, Hypothyroidism, Hypertension, and Depressive Disorder.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 21 Medical record review of the Physician's admission orders dated July 24, 2014, revealed orders for home medications including Seroquel 200 mg qhs [every hour of sleep], Sertraline 25 mg qhs, Pravastatin 40 mg qhs, and Risperidone 0.5 mg qhs. Review of a facility investigation dated July 25, 2014, revealed the resident was not given Seroquel 200 mg, Sertraline 25 mg, Pravastatin 40 mg, and Risperidone 0.5 mg, on the evening of July 24, 2014, due to a transcription error. Continued review revealed the medications had been given to another resident in error. Interview with PCC #8 on September 23, 2014, at 3:50 p.m., in the hall, outside the Director of Nursing (DON)'s office, confirmed the resident and family had not been notified of the omission of medications. Resident #23 was admitted to the facility on July 29, 2014, with diagnoses of Diastolic Heart Failure, Pressure Ulcer, Esophageal Reflux, and Muscle Weakness. Medical record review of the resident's admission orders revealed an order for Restoril (a sleeping pill) 15 mg every night as needed (PRN). Medical record review of the resident's MAR revealed the medication was on the MAR as a routine medication and a PRN medication. Continued review revealed the medication had been administered to the resident as a routine medication eight times from July 29, through August 5, 2014.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 22	F 157		

Review of a facility investigation dated August 7, 2014, revealed the order for Restoril was put into the computer as routine and an additional order was put in for Restoril 15 mg QHS PRN. Continued review revealed the reason for the occurrence was the order was not entered correctly upon admission.

Interview with the DON on September 30, 2014, at 3:00 p.m., in the DON's office, confirmed the family had not been notified of the medication error.

Resident #411 was admitted to the facility on August 2, 2014, with admitting diagnoses of Post Lumbar Laminectomy, Hypertension, Muscle Weakness, and Difficulty in Walking.

Medical record review of a physician's order dated August 5, 2014, revealed an order for a one-time dose of Dulcolax Suppository (a stool softener) and a one-time dose for a bottle of Magnesium Citrate (a bowel cleansing agent) in the morning of August 6, 2014.

Medical record review of the MAR for August, 2014, revealed "...08/05/14 Dulcolax 10 mg SUP [suppository] [Bisacodyl] rectal once a day for constipation...start date: 08/06/14...stop date: 08/28/14..." and "...08/05/14 Magnesium Citrate 1.75 GM [grams]/30 ml sol [Magnesium Citrate] oral once a day for constipation...start date: 08/06/14...stop date: 08/28/14..." The Dulcolax and Magnesium Citrate had been initialed as held, due to resident refusal, on the morning of August 6, and had been initialed as given on August 9, 10, and 25, 2014, for a total of three doses of each medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 23	F 157		

Review of a facility investigation dated September 4, 2014, revealed "...med order was Dulcolax Supp. X I in am, order was processed as Dulcolax Supp. PR (rectally) daily @ (at) 9:00 this was on emar (electronic medication administration record) x (times) twenty three days but pt. refused all but three doses. [RN #11] notified me of error on 8/28/14 [date of discharge]...[there was total of 2 extra doses given], cause of occurrence: order not processed correctly..."

Interview with the DON on September 30, 2014, at 3:00 p.m., in the DON's office, confirmed the family had not been notified of the medication error.

Resident #238 was admitted to the facility on August 14, 2014, with diagnoses including Aortocoronary Bypass, Dysphagia, Muscle Weakness, and Difficulty in Walking, Diabetes, Hypertension, and Hyperlipidemia.

Review of the Admission MDS dated August 27, 2014, revealed the resident had a BIMS of 13 (resident cognitively intact).

Medical record review of the Physician Orders dated August 2014 revealed an order "...August 14, 2014, Furosemide [diuretic medication] 20 mg [milligram] tab [tablet] oral daily @ 6 am for edema..."

Medical record review of the Physician's Orders dated August 19, 2014 revealed "...Lasix [Furosemide] 40 mg po [by mouth] now [immediately] and give another 20 mg at 6 pm...Increase Lasix in am to 40 mg daily..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 157	Continued From page 24 Medical record review of the Physician Telephone Orders dated August 20, 2014 revealed "...D/C [discontinue] Lasix..." Medical record review of the Medication Record dated August 2014 revealed the resident received Furosemide 40 mg daily on August 21 and August 22, 2014, two days after the medication had been discontinued. Medical record review of the Medication Record dated August 2014 revealed the resident did not receive the now dose of medication as ordered on August 19, 2014. Review of the facility investigation prepared August 22, 2014, revealed "...Drug name Lasix...Medication Order D/C Lasix...Wrong Dosage...Cause of Error Order Not Signed Off Correctly...Lasix was discontinued...Was patient aware of medication error? No... Drug had been entered in under generic name as well so not noticed when signing order... Admission orders had generic name and NP wrote for Brand name to be discontinued. WC and RN did not catch generic name..." Review of the facility investigation with date received August 29, 2014 revealed "...Chart Check Error...Did Not Read Drug Label...Incorrect Order Confirmation...Transcription Error...Comments: Admission orders listed meds in generic forms. NP stopped it but called by brand name...RN did not catch the generic form of the drug when signing off orders and the 24 hour chart check did not catch it neither..." Interview with the CE/QA Nurse on September	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 157	Continued From page 25	F 157		

25, 2014 at 1:41 p.m., in the conference room, confirmed the facility failed to notify the resident of the medication errors.

Interview with RN #6 on September 29, 2014 at 9:21 a.m., in the conference room, confirmed the facility failed to follow policy and notify the resident.

Interview with CE/QA Nurse on September 29, 2014 at 4:47 p.m., in the conference room, revealed three medication errors occurred: the Lasix 40 mg now was not given August 19, 2014; Furosemide 40 mg was given August 21, 2014; and Furosemide 40 mg was given August 22, 2014.

Interview with RN #3 PCC on September 30, 2014, at 8:37 a.m., in the conference room, confirmed "...I don't notify anybody..." Further interview revealed the facility had failed to notify resident.

Interview with the CE/QA Nurse on September 30, 2014, at 8:37 a.m., in the Classroom, confirmed the facility does not immediately notify residents or resident's family of medication errors.

Interview with the Administrator on September 30, 2014 at 10:12 a.m., in the conference room, confirmed "...The residents and families are not notified consistently of medication errors..." Continued interview confirmed "...Our policy says we need to notify them..."

Resident #388 was admitted to the facility on August 8, 2014, with diagnoses including Rehabilitation, Cellulitis of the Leg, and Pressure Ulcer of the Buttock, Congestive Heart Failure,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 157	Continued From page 26	F 157		

and Diabetes Mellitus.

Medical record review of the facility's Nutritional History dated August 18, 2014, revealed an admission weight of 99.4 pounds, UBW (Usual Body Weight) of 96 pounds, and a BMI (Body Mass Index) of 18 (normal 18.5-24.9). Continued review revealed a diet order of "CCHO [Consistent Carbohydrate Diet] c [with] glucerna c meals/Regular. Glucerna TID [three times a day]."

Medical record review of the 5 day MDS dated August 22, 2014, revealed the resident had a BIMS of 9 (indicating moderate impairment); needed supervision for eating, set-up only; and had a weight of 99 pounds.

Medical record review of the Plan of Care dated August 28, 2014, revealed "...Needs therapeutic diet related to low BMI...interventions...Regular diet with Glucerna once daily, monitor meal consumption offering substitutes if resident consumes less than 50% of meals..."

Medical record review of resident #388's weight dated September 7, 2014, revealed the resident weighed 95 pounds (4.1% loss). Continued review of a weight dated September 22, 2014, revealed the resident weighed 91 pounds (8.1% loss).

Medical record review of the 30 day MDS dated September 11, 2014, revealed the resident had a BIMS of 10 (cognitively intact); needed supervision for eating, set-up only; and had a weight of 95 pounds.

Medical record review of the Interdisciplinary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 27	F 157		

Progress Notes dated August 25 to September 23, 2014, revealed no documentation of weight loss.

Medical record review of the facility's Meal & (and) Fluid Detail Report dated August 24 to September 21, 2014, revealed documentation the resident only received the Glucerna on September 5 and 6, 2014.

Review of the facility policy, Supervision of Resident Nutrition, revised October 2009, revealed "...food and fluid intake must be observed...recorded and reported...information must be provided to the attending physician, certified dietary manager, and registered dietitian..."

Interview with the RN #2 Charge Nurse on September 23, 2014, at 4:00 p.m., in the main nursing station, confirmed the RN had no knowledge of the weight loss.

Interview with the Registered Dietician (RD) on September 23, 2014, at 4:30 p.m., in the dining room, confirmed the nutritional supplement was not documented and the RD was not aware of the weight loss. Continued interview revealed the RD had no further dietary consults for resident #388.

Interview with the DON on September 24, 2014, at 7:45 a.m., in the main floor nursing station, confirmed the facility had failed to notify the dietitian or the physician of the weight loss.

The Immediate Jeopardy was effective from February 12 through October 1, 2014, and was removed onsite on October 2, 2014. An Acceptable Allegation of Compliance, which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 28 removed the immediacy of the jeopardy, was received and corrective actions were validated by the surveyors through review of documents, staff interviews, and observations conducted onsite on October 2, 2014. The surveyors verified the allegation of compliance by: 1. Verification through interview with Director of Nursing and review of the Medication Occurrence Report modified to require the date and time of notification of resident and/or family of medication errors. 2. Review of the facility's in-service records to ensure nursing staff were educated regarding changes for notification. Review included the facility's plan of action to ensure all nurses were educated on the new system before being allowed to work a shift (coordinated by the Director of Nursing), and the facility's plan for education for nurses who were not scheduled to work or who were on vacation or Family Medical Leave. 3. Verification through interview with the Administrator, and review of facility documentation the facility's identification of eight transcription errors during the facility's audit of all current resident's medication orders. Review of facility documentation verified residents or resident's family, and physician were notified of the errors. Verification through interview with the Medical Director of immediate intervention to assess resident's status after identification of the error, and provide clarification orders where needed. 4. Verification through interviews with nine Registered Nurses, seven Licensed Practical Nurses, and three Ward Clerks/Certified Nursing Assistants to determine the comprehension gained through in-services conducted by the	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 157	Continued From page 29 Director of Nursing regarding the changes and implementation of the facility's new procedures. 5. Verification through interview with the Administrator, Medical Director, Chief Nursing Officer, Risk Management Team, Director of Nursing, and Director of the Pharmacy Vendor of their participation in risk management meeting to address the system changes. Non-compliance continues at an "F" level for monitoring the effectiveness of corrective actions and evaluation of monitoring by the Quality Assurance Committee. The facility is required to submit a plan of correction.	F 157		
F 226 SS=D	C/O #34603 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, interview, and facility policy review, the facility failed to ensure staff reported an allegation of physical abuse for one resident (#446) of twenty-seven residents reviewed. The findings included: Resident #446 was admitted to the facility on September 18, 2014, with diagnoses including	F 226	F226 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #446 was discharged on October 13, 2014 from the Transitional Care Center (TCC) (facility) without injury or further incident. She was discharged to home under the care and supervision of her family with Home Health Services to follow. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Immediately following the allegation by resident #446, the Social Worker educated staff present on October 3, 2014 through October 11, 2014 on the "Abuse Investigation and Reporting" policy (see exhibit 8) in use at the time (revision version dated August 20, 2014 by the Administrator, Director of Nursing (DON), Clinical Educator (CE), and Social Services), and documented review and understanding of the policy as evidenced by signed rosters (see exhibit 9).	10/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 226	Continued From page 30 Intestinal Infections, Systemic Inflammatory Response Syndrome, Pyelonephritis, Muscle Weakness, Difficulty in Walking, and Left Lung Mass. Medical record review of the 5-day Minimum Data Set (MDS) Assessment dated September 18, 2014, revealed the resident was cognitively intact. Continued review revealed the resident required physical assistance of two persons for bed mobility, transfers, walking in room, toilet use, and bathing. Interview with resident #446 on September 22, 2014, at 11:00 a.m., in the resident's room, revealed "...on the first or second night...had a nurse be rough with me...she was cleaning me up and turning me in bed..." Continued interview revealed the incident happened "...maybe after midnight..." The resident stated told the person "you're rough" and the person replied "well I might not be so rough if you would help yourself." Continued interview revealed the incident was reported "...to some of the girls...staff members...a day or two later..." Review of facility policy Abuse Prevention with a revision date of March 2008 revealed "...B. Training of staff in interventions, reporting, detection...what constitutes abuse..." Review of facility policy Abuse Investigation and Reporting with a revision date of January 2014 revealed "...B. All personnel...to report incidents of resident abuse or suspected incidents of abuse..." Continued review revealed "...E. The person(s) observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the charge nurse..."	F 226	In addition, in order to identify other residents having the potential to be affected, on September 24, 2014, the Social Worker, upon recommendation of the Ombudsman who was present on that date, visited all patients from room 101 to room 115 to determine if any other residents cared for by the same staff as resident #446 had any complaints or allegations of abuse. None were reported. The Ombudsman conducted rounds within the facility on September 24, 2014, evaluating for signs of abuse or concerns voiced by residents. She found none. Continuing after the date of allegation, the Social Worker conducts rounds on residents on days 5 and 14 of the Minimum Data Set (MDS) review questioning all residents present on those dates about any concerns related to abuse or quality of care. On October 8, 2014 staff huddles began and included education on what constitutes abuse, instruction to be alert for any indications of abuse, and how to report any allegation of abuse. Huddles are small and informal meetings involving Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nurse Assistants (CNAs), and ward clerks (WCs) present that shift. They are held at the beginning of each shift daily and conducted by the RN charge nurse. They provide a brief discussion of any announcements, reminders, or updates and content is determined by the Nursing Leadership Meeting (see exhibit 10). Content from huddles is also documented in a huddle book so that staff not present may review it as well. Educational in-service (see exhibit 4) on what constitutes abuse and how to report it was conducted by the Interim DON, Interim CE, and Patient Care Coordinators (PCCs) from October 22, 2014 – October 25, 2014, and included all RNs, CNAs, LPNs, and WCs. The "Abuse Investigation and Reporting" policy (see exhibit 8) was reviewed and revised on October 22, 2014 with input by Nursing, Social Services, TCC Administrator, and the TCC Medical Director to ensure full compliance with Resident Rights.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 31 Interview with the Director of Nursing (DON) on September 23, 2014, at 3:40 p.m., in the DON's office, revealed no allegations of abuse had been investigated regarding resident #446. Interview with Certified Nurse Assistant (CNA) #2 on September 24, 2014, at 7:38 a.m., in the main dining room, revealed "...work 7am to 7pm...last week I worked Thursday and was off Friday, Saturday and Sunday..." Continued interview with CNA #2 revealed "...overheard staff talking about a...patient who had said someone had been rough with them...this was on Thursday night...wasn't part of conversation...had three CNAs on Thursday night..." Telephone interview with Licensed Practical Nurse (LPN) #1 on September 24, 2014, at 10:22 a.m., revealed "...was working last Thursday...no one reported anything..." Continued interview confirmed the LPN denied hearing any discussions or being a part of discussion regarding the resident's allegation of physical abuse. Further interview confirmed no staff or resident reported an allegation of abuse to the LPN. Telephone interview with Registered Nurse (RN) #10 on September 24, 2014, at 2:20 p.m. revealed "...do not provide direct care...just round...check on everyone..." Continued interview confirmed the RN denied hearing any discussions or being a part of discussion regarding the resident's allegation of physical abuse. Further interview confirmed no staff or resident reported an allegation of abuse to the RN.	F 226	It was approved by the Interim DON, Chief Nursing Officer (CNO), and Medical Director and went into effect on October 25, 2014. Copies of the "Abuse Investigation and Reporting" policy (see exhibit 8) were distributed and reviewed with the staff by the instructors during these educational sessions and staff questions were answered. Two staff were on vacation during this in-service and completed their education to this policy by October 27, 2014 (see exhibit 11). New or contract staff will receive education to this policy (see exhibit 8) as part of their new employee orientation packet. This educational material will be updated as policy changes occur by the CE. The CE will also be responsible for educating current RNs, LPNs, CNAs, and WCs of policy changes when they occur. The TCC (facility) staff of other departments (Dietary, Housekeeping, Laundry, Therapy, Administrative/Office staff) were provided a copy of the "Abuse Investigation and Reporting" policy (see exhibit 8) and required to review it and verify their understanding. This review and verification was documented via their signature on a roster (see exhibit 11). Contracted Services and Hospital staff who currently provide services at TCC are required to read the revised policy and sign the "Abuse Investigation and Reporting" roster (see exhibit 11) during their next visit at TCC and prior to providing care and services. On October 23, 2014, the hospital departments that provide services to TCC received instructions from the Interim DON relative to the requirement for their staff to complete this education and the process for completion and documentation of completion (see exhibit 12). What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; The "Abuse Investigation and Reporting" policy (see exhibit 8) was reviewed and revised on October 22, 2014 with input by Nursing, Social Services, and the TCC (facility) Medical Director to ensure full compliance with Resident Rights. It was approved by the Interim DON, CNO, and Medical Director and went into effect on October 25, 2014. Continued on Page 32(a)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING_____ B. WING_____	10/02/2014

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PARKWAY MARYVILE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 32	F 226	This policy states that all abuse allegations will be reported immediately to the appropriate supervisor on duty at the time of the occurrence. The supervisor will notify the DON, Administrator, Medical Director, and Attending Physician. As indicated, staff member(s) will be suspended, and a full investigation of the allegation will be initiated immediately. Beginning October 27, 2014, any violations of the policy will result in disciplinary action. Educational in-service (see exhibit 4) on this policy was conducted by the Interim DON, Interim CE, and PCCs from October 22, 2014 through October 25, 2014, and included all RNs, CNAs, LPNs, and WCs. Copies of the policy were distributed and reviewed with the staff by the instructors during these educational sessions and staff questions were answered. Two staff members were on vacation during this in-service and completed their education to this policy by October 27, 2014 (see exhibit 11). This policy was in effect as of October 25, 2014. New or contract staff will receive education to this policy (see exhibit 8) as part of their new employee orientation packet. This educational material will be updated as policy changes occur by the CE. The CE will also be responsible for educating current RNs, LPNs, CNAs, and WCs of policy changes when they occur. The TCC (facility) staff of other departments (Dietary, Housekeeping, Laundry, Therapy, Administrative/Office staff) were provided a copy of the "Abuse Investigation and Reporting" policy (see exhibit 8) and required to review it and sign a roster to verify their understanding (see exhibit 11). The Interim DON and Interim CE were listed as resources for any questions regarding this policy. This was completed by October 28, 2014 for all staff that have worked at TCC to date. Additional staff will be educated in this same manner as they come in for their next scheduled shift.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

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F 226	Continued From page 32 (a)	F 226	Contracted Services and Hospital staff who currently provide services at TCC are required to read the revised policy and procedure and sign the "Abuse Investigation and Reporting" roster (see exhibit 11) during their next visit at TCC and prior to providing care and services. On October 23, 2014, the hospital departments that provide services to TCC received instructions relative to the requirement for their staff to complete this education and the process for completion and documentation of completion (see exhibit 12). How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. All allegations of abuse are being reviewed daily in the Nursing Leadership Meeting which occurs at 8:00am Monday through Friday and is attended by the Administrator, DON, PCCs, CE, and Medical Director at her discretion or as requested. During this meeting, a general review of occurrences including allegations of abuse and neglect is discussed (see exhibit 7). Since it was created, the CMO, CNO, and Medical Director have attended daily to ensure the Nursing Leadership Meeting is accomplishing its function. All allegations of abuse are being reviewed weekly starting October 6, 2014 by the TCC Medication Error/ Risk Team. This team meets weekly on Mondays at 1:30pm and includes the TCC Medical Director, TCC Administrator, Hospital CMO, Hospital CNO, Consultant Pharmacist, Hospital Associate Nurse Executive, TCC DON, TCC PCC, TCC CE, Hospital Risk Manager, and Hospital Quality Management Director. In addition to other responsibilities, the Medication Error Team/Risk Team reviews all allegations of abuse and neglect (see exhibit 13).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING_____ B. WING_____	10/02/2014

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PARKWAY MARYVILE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 32 (b)	F 226	All allegations of abuse are being reviewed monthly in the TCC (facility) Quality Assurance (QA) Committee. This team meets monthly on the third Wednesday of the month at 11:30am and includes the TCC Administrator, TCC Medical Director, DON, CE, PCCs, Department Heads including the Social Services Representative, Registered Dietician, MDS coordinator, and the Pharmacy Consultant. The purpose of the QA Committee is to provide general oversight for the quality of care at the facility (see exhibit 14). All allegations of abuse are being reviewed quarterly at the TCC (facility) Advisory Committee. This team meets quarterly on the Fourth Wednesday of the month following the end of the quarter at 7:00am and includes the TCC Administrator, TCC Medical Director, DON, CNO, CE, PCCs, Department Heads including the Social Services Representative, Registered Dietician, MDS coordinator, the Pharmacy Consultant, and community physician representative (see exhibit 15). Additional actions will be taken based upon recommendations these committees.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 226	Continued From page 32 Interview with the DON on September 25, 2014, at 11:01 a.m., in DON's office, revealed CNA #7 had been interviewed by the DON on the evening of September 24, 2014. Continued interview revealed CNA #7 had assisted CNA #2 in the care of resident #446 on the evening of September 18, 2014, and had witnessed the resident's allegation of physical abuse. Telephone interview with CNA #7 on September 25, 2014, at 11:17 a.m., revealed "...work 7p to 7a...believe I was working last Thursday...thought...needed to call back...small little ordeal..." Continued interview revealed "...helping change...did not think abusive...resident pointed at (CNA #2) and said 'you're rough'..." Continued interview revealed "...since...wasn't my patient...should have reported but doing it now...I know now to report it even though it didn't look bad...thought about it...decided to tell them about it..." Interview with the DON and the Administrator on September 25, 2014, at 11:31 a.m., in the DON's office, revealed "...CNA #2 has been suspended pending investigation...make sure...understands what was supposed to happen..." Continued interview confirmed CNA #7 did not follow facility policy for reporting an allegation of abuse.	F 226	Continued From Page 32(c)	
F 281 SS=L	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	10/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

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F 281	Continued From page 33 Based on review of Lippincott Manual of Nursing Practice, review of the Rules and Regulations of Licensed Practical Nurses, review of facility policy and procedures, medical record review, review of facility investigation, and interview, the facility failed to follow facility policy for transcribing medication orders, reconciling physician's orders with medication administration records, and for completing 24 hour chart checks to ensure no medication errors occurred. The failure resulted in medication errors and placed sixteen residents (#262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238) of twenty-four residents reviewed for medication errors in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death). The facility's failure was likely to place any resident who received medications at risk for immediate jeopardy. The Administrator, Medical Director, Chief Medical Officer/In House Legal Counsel, Chief Nursing Officer, and Director of Nursing were informed of the Immediate Jeopardy on September 30, 2014, at 4:00 p.m., in the conference room. The Immediate Jeopardy was effective February 12, 2014 through October 1, 2014. An extended survey was conducted September 30 - October 2, 2014. The facility submitted an Acceptable Allegation of Compliance to the survey team on October 2, 2014. The survey team verified the actions taken by the facility removed the immediacy of the	F 281	The medication errors of residents #262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238 have been additionally reviewed by the Transitional Care Center (TCC) (facility) Medical Director and Nursing Leadership Team on October 21, 2014. This team (created on October 7, 2014) meets at 8:00am Monday through Friday and is attended by the TCC Administrator, Director of Nursing (DON), Patient Care Coordinators (PCCs), Clinical Educator (CE), and Medical Director at her discretion or as requested. During this meeting, a general review of medication occurrences including medication errors and ensuring appropriate notification has been completed is discussed (see exhibit 7). Since it has been created the Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and Medical Director have attended daily to ensure the Nursing Leadership Meeting is accomplishing its function. None of these residents suffered a prolonged or permanent condition from the noted medication errors. Each resident was discharged as indicated below: #262 to Blount Memorial Hospital on July 25, 2014. She was discharged from the hospital to a second skilled nursing facility from which she was later discharged to home in good condition. #457 to home on March 31, 2014 #453 to home with Home Health on March 24, 2014 #452 to home on February 21, 2014 #454 to home with Home Health on March 19, 2014 #455 to home with Home Health on April 12, 2014 #456 to an Intermediate Care facility on April 9, 2014 #279 to home with Home Health on May 8, 2014 #111 to home with Home Health on August 10, 2014	

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F 281	Continued From page 34 jeopardy on October 2, 2014. Noncompliance continues at the "F" level. The findings included: Review of Lippincott Manual of Nursing Practice, Ninth Edition, revealed, "...Chapter 2 Standards of Care, Ethical and Legal Issues...Accountability...Maintaining familiarity of relevant, current facility policies, procedures, and regulations as they apply to the nurse's practice and specialty area...Examining the quality (accuracy and completeness) of documentation...Common Departures from the Standards of Nursing Care...failure to...follow physician orders, follow appropriate nursing measures...adhere to facility policy or procedure...administer medications as ordered, and follow physician's orders that should have been questioned or not followed, such as orders containing medication dosage errors..." Review of the facility Medication Administration General Guidelines revealed "...Medications are administered as prescribed, in accordance with good nursing principles and practices and only persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication...Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a medication order seems unrelated to the resident's current diagnosis or condition, the physician is contacted for clarification prior to the administration of the medication..." Review of the facility policy Charge Nurse with	F 281	#398 to home with Home Health on August 7, 2014 #105 to home with Home Health on August 14, 2014 #197 to home with Home Health on August 8, 2014 #23 to home with Home Health on September 4, 2014 #411 to home on August 29, 2014 #238 to home on September 30, 2014 It was determined for resident #188, after additional review of the medical record, the medication dispensing system reports, and pharmacy records, that the resident did not receive Coumadin as documented by the nurse. The nurse entry was inaccurate. This staff member no longer works at TCC (facility). In complete review of chart, there was NO order for Coumadin 2 mg to be given to the resident. However, an electronic request was sent to pharmacy for Coumadin 2 mg. Pharmacy rejected the order due to admission order clarification for "hold Coumadin". They notified TCC (facility) of rejection of order. The pharmacy (which generates Coumadin orders per protocol) did not generate a Coumadin order for this resident. There was no Coumadin withdrawn from medication dispensing system profile assigned to this resident. Resident #188 was discharged home to Assisted Living with Hospice to follow on April 11, 2014. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents in the TCC (facility) were considered to have the potential to be affected. The Electronic Medication Administration Record (E-MAR), Electronic Treatment Administration Record (E-TAR), and Electronic Physician Order Entry (E-POE) system were abandoned immediately on September 30, 2014, returning to a hand-written, paper-based MAR, TAR, and physician order system, effective October 1, 2014.	

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F 281	Continued From page 35 revision date October 2012 revealed "...the charge nurse, at a minimum, is responsible for... reviewing medication cards for completeness of information, accuracy in the transcription of physician orders, and adherence to stop order policies..." Review of the facility procedure Night Shift RN (Registered Nurse) Checklist undated revealed "...check charts after midnight (24 hr [hour] chart checks). If any new medicines ordered, verify they were on the MAR [Medication Administration Record - record for documenting medication administration]..." Resident #262 was admitted to the facility on July 23, 2014 with diagnoses of Pneumonia, Acute Renal Failure, Rehabilitation, Atrial Flutter, and Muscle Weakness. Medical record review of the Medication Administration Record (MAR) for July 2014, revealed on July 24, 2014, at 9:00 p.m., the resident was given Seroquel (an antipsychotic medication) 200 mg (milligrams), Sertraline 25 mg (an antidepressant), Pravastatin 40 mg (an anti-cholesterol medication), and Risperidone 0.5 mg (an antipsychotic medication). Medical record review of Physician's orders from July 23 through July 25, 2014, revealed no orders for Seroquel 200 mg, Sertraline 25 mg, Pravastatin 40 mg, or Resperidone 0.5 mg. Review of the facility investigation initiated July 24, 2014 revealed resident #262 was given Seroquel 200 mg Sertraline 25 mg, Pravastatin 40 mg, and Risperdal 0.5 mg one time. Further review of the facility investigation revealed	F 281	On September 30, 2014 through October 1, 2014, charts and MARs of 100% of the current residents (68) were reviewed during our conversion from E-MAR to paper MAR. In the process, the records were analyzed for any medication errors by the Medical Director who was on site through the entire conversion process. Our initial review identified 7 residents (8 errors) who we thought were affected. However, on further review, one resident (MR# 425745) had previously been notified of the error and another (one of two on MR# 448221) was found not to be an error. The following residents were affected: Resident MR# 475365: Omission of medication on September 14, 2014 Resident MR# 483234: Transcription error on September 18, 2014 Resident MR# 689434: Transcription error on September 25, 2014 Resident MR# 791005: Transcription error on September 23, 2014 Resident: MR# 524029: Transcription error on September 5, 2014 Resident MR# 448221: Transcription error on September 15, 2014 Starting September 30, 2014, additional Registered Nurses (RNs), employed by Parent Hospital (Blount Memorial) were assigned to TCC to complete the following tasks: • Transcribe all physician orders for every current resident to a hand-written MAR and/or TAR on September 30, 2014 for immediate use. • Verify (2 RN's) accuracy of all physician orders for every current resident to a hand-written MAR and/or TAR after transcription completed on October 1, 2014.	

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F 281	Continued From page 36 "...orders from one new admission were put on a pt. [patient] that had already been there x [times] 2 days...WC [Ward Clerk] was still in a new admission profile & [and] went into [resident #262] profile did not switch back to the new admission profile, new admission meds put in [resident #262's] profile..." Medical record review of a facility Discharge Summary dated July 25, 2014, revealed "...Pt discharged to hospital, dx [diagnosis]: accidental overdose..." Telephone interview with Registered Nurse (RN) #5 on September 23, 2014, at 8:45 a.m., revealed RN #5 had taken resident #262's chart to the ward clerk to correct an order in the computer; the ward clerk had made the correction and then transcribed resident #197's new admission orders for Seroquel 200 mg every night, Sertraline 25 mg every night, Pravastatin 40 mg every night, and Risperdal 0.5 mg every night, from the computer screen into resident #262's MAR on July 24, 2014, at 9:44 p.m. Continued interview confirmed the order was discovered during the 24 hour check by RN #5 at 4:00 a.m., (error was not caught when the RN was to have verified all new orders transcribed by the ward clerk) and RN #5 had failed to follow policy for ensuring accuracy in the transcription of physician orders. Telephone interview with Licensed Practical Nurse (LPN) #8 on September 23, 2014, at 9:31 a.m., confirmed the Seroquel, Sertraline, Pravastatin, and Risperdal were given in error to the resident on July 24, 2014, at 9:00 p.m., and LPN #8 failed to follow policy for ensuring accuracy in the transcription of physician orders and the 24 hour chart checks.	F 281	• Provide every 12 hour chart checks to include review of all MAR, TAR, and new physician orders effective October 1, 2014. This process is ongoing. • Administer all medications under the purview of two licensed nurses (RN or Licensed Practical Nurse (LPN)) effective October 1, 2014. This process is ongoing. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; Initial education on the transcription and verification process (see exhibit 16) was completed by the CNO on September 30, 2014 during a face to face educational session with all RNs and LPNs present that shift. For the subsequent shifts on September 30, 2014 and October 1, 2014, the DON reviewed the Allegation of Compliance and the process for transcribing and verifying MARs and TARs, chart check process, and new medication occurrence report, with each shift's RNs and LPNs (see exhibit 16). From October 1, 2014 through October 16, 2014 the TCC Medical Director, CNO, Interim DON, Interim CE, and Pharmacy Director developed a process for utilizing a printed MAR established by the pharmacy. This process is outlined in the "Medication Administration" policy (see exhibit 17) which was a new policy that was created, reviewed, and discussed on October 22, 2014 with approval by the Interim DON, CNO, Associate Nurse Executive, and Medical Director and this policy describes the transcription and verification process. This policy was implemented October 25, 2014.	

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F 281	Continued From page 37 Interview with ward clerk #1 on September 29, 2014, at 2:50 p.m., in the DON's (Director of Nursing) office, confirmed the ward clerk was not aware of the medication error and confirmed the ward clerk had not followed transcription policy. Resident #457 was admitted to the facility on March 14, 2014, with diagnoses including Acute Venous Embolism and Thrombosis of Lower Extremity, and Fractured Hip. Medical record review of the Hospital Discharge Medication List dated March 14, 2014, revealed "...enoxaparin [a medication to prevent blood clots]...0.4 ml [milliliters], subcutaneous [injection given into the tissue just under the skin], every 24 hours..." Medical record review of the Physician's Recapitulation Orders dated March 14, 2014, revealed "...Enoxaparin...40 mg/0.4 ml sol [solution] give 0.4 ml...subcutaneous once a day for blood clotting control..." Medical record review of the MAR dated March 14, 2014, through March 20, 2014, revealed the days for administration of the medication was indicated as every other day and and the resident did not receive Enoxaparin 40 mg subcutaneous on March 15 and March 17, 2014. Medical record review of the Medication Record dated March 14, 2014, through March 20, 2014, revealed resident #457 did not receive the Enoxaparin 40 mg subcutaneous on March 15 and March 17, 2014. Medical record review of a Physician's Order	F 281	Educational in-service (see exhibit 4) on this policy was conducted by Interim DON, Interim CE, and PCCs from October 22, 2014 through October 25, 2014, and included all RNs, LPNs, Certified Nurse Assistants (CNAs), and Ward Clerks (WCs). Two staff members were on vacation during this in-service and completed their education (see exhibit 5) to this policy by October 27, 2014. New or contract staff will receive education to this policy (see exhibit 17) as part of their new employee orientation packet. This educational material will be updated as policy changes occur by the CE. The CE will also be responsible for educating current RNs, LPNs, CNAs, and WCs of policy changes when they occur. In accordance with standards of professional nursing practice as set forth in the "Lippincott Manual of Nursing Practice, 10th Edition, 2014," nursing staff has been educated to adhere to TCC (facility) policies regarding medication transcription, verification, administration, and error reporting. Education was conducted October 22, 2014 through October 25, 2014. It was administered by the CE, the Interim DON, and the PCCs. Education was provided to RNs, LPNs, CNAs, and WCs who were required to indicate understanding of all educational materials via their signature. Materials provided to nursing staff included the Nurse Education Packet (see exhibit 4) and clarification and instructional memos (see exhibit 18). The week of October 27, 2014 a separate RN education packet (see exhibit 19) was provided for clarification and reinforcement of previous education. Beginning on October 17, 2014 the TCC (facility) now receives a printed MAR from the pharmacy every day for the next 24 hour period. These MARs are reviewed by two RNs for accuracy prior to use for medication pass by TCC (facility) nurses (RNs or LPNs). How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.	

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F 281	Continued From page 38 dated March 18, 2014, revealed "...Vascular US [ultrasound] RLE [right lower extremity] Dx: [diagnosis] warmth, edema [swelling]...Dx: chills, warm, swollen RLE..." Medical record review of a Diagnostic Report dated March 19, 2014, revealed "...Exam...Lower Venous Right...Clinical: RLE Edema and Warmth...Findings...Significant nonocclusive thrombus [blood clot] is seen within the right posterior tibial and peroneal veins...Impression: significant nonocclusive thrombus below the knee within the right peroneal and posterior tibial veins..." Medical record review of a Physician's Progress Note dated March 19, 2014, revealed "...results RLE doppler show nonocclusive thrombus below knee [within] right peroneal [and] post tibial veins. Pt has had erythema [redness]/edema x 2 days..." Medical record review of a Physician's Order dated March 19, 2014, revealed "...lovenox [enoxaparin] 1 mg/kg [kilogram] SQ [subcutaneous] every 12 hours...clarified with pharmacy to give lovenox 100 mg sq q [every] 12 hours...give additional 60 mg lovenox to equal to 100 mg lovenox today..." Review of the facility investigation dated March 20, 2014, revealed "...Error when entering order. clicked frequency options and entered every 2 days...suggest to prevent similar occurrences? Read order thoroughly recheck after entered for accuracy..." Review of the facility investigation dated March 21, 2014, revealed "...Event Date:	F 281	Beginning October 1, 2014 only RNs have been permitted to transcribe medication and treatment orders. On October 10, 2014, Hospital Quality Management Department began performing audits (see exhibit 20) of 100% of the facility's residents' charts each day to ensure that the following processes are completed: • Verification that 2 RNs have deemed all physician orders accurate for every current resident • 12 hour chart checks are completed on every resident each shift including review of all MARs, TARs, and new physician orders • Two nurses have reviewed every medication administered to every resident If the Quality Management Department finds deficiencies during their audits, they communicate these to the DON. Deviations from these practices as of October 27, 2014 will result in employee re-education and/or disciplinary action by the DON. The TCC Medication Error/Risk Team began on October 6, 2014, and was tasked to evaluate compliance with the process defined in the policy "Medication Administration" (see exhibit 17). This team evaluates all medication error occurrences, and reviews medication error rates in the weekly meeting. Error rates are determined by the number of medication errors per month divided by the total number of doses administered that month. The goal is to have no medication errors, but in the event an error occurs, this team ensures that a robust investigation and evaluation ensues. The TCC Medication Error/Risk Team meets every Monday at 1:30pm and includes the TCC Medical Director, TCC Administrator, Hospital CMO, CNO, Consultant Pharmacist, Hospital Associate Nurse Executive, TCC DON, TCC PCC, TCC CE, Hospital Risk Manager, and Hospital Quality Management Director.	

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F 281	Continued From page 39 3/14/2014...Order entry error off admission orders from [named hospital]. WC [ward clerk] changed the frequency of the med [medication] dosing which should not have been adjusted. Nurse did not notice the change in time frequencies...Medication involved: Enoxaparin [Lovenox]..." Medical record review of the physician's order dated March 21, 2014, revealed "...Continue Lovenox 100 mg SQ Q 12h [hour]...for new onset DVT [Deep Vein Thrombosis]..." Interview with the Clinical Educator/Quality Assurance (CE/QA) Nurse, on September 29, 2014, at 8:30 a.m., in the conference room, confirmed the Lovenox order was transcribed incorrectly, entered as every other day, and the resident missed the dose on March 15 and 17, 2014. Continued interview confirmed the ward clerk entered the order incorrectly with the frequency of every other day. Interview with Registered Nurse (RN) #6 on September 29, 2014, at 9:10 a.m., in the conference room, confirmed RN #6 was responsible for verifying the order of Lovenox and failed to verify the order for accuracy. Continued interview confirmed the RN signed the twenty-four hour chart check on March 15, 2014, and did not identify the error. Interview with Nurse Practitioner (NP) #1 on September 29, 2014, at 11:00 a.m., in the conference room, confirmed it would be possible the missed doses contributed to the development of the DVT. Interview with the Medical Director on September	F 281	In addition to other responsibilities (see exhibit 13), the Medication Error Team/Risk Team reviews all medication occurrence reports (see exhibit 6), identifies negative trends from the analysis of data we enter in our medication error database, and reviews the Hospital Quality Management audit results weekly. The team will also discuss any Safety Hotline calls made concerning medication errors or medication administration processes at TCC. This Hotline is used to report conditions affecting clinical resident safety or quality of care issues including medication errors or concerns. Calls may be left anonymously or callers may leave contact information. The calls are transcribed by the Quality Management Department at the hospital and reviewed individually by the Hospital Risk Manager and the CMO. The Hospital Safety Hotline phone number is posted in staff work areas. Beginning October 27, 2014, a systematic plan for audit frequency will be followed (see exhibit 21). During the consultant pharmacist's weekly visit, the pharmacist will audit at least 10 residents' MARs for accuracy and completeness of profile. This number was determined based on an average admission volume of about 20 residents per week. The residents audited are chosen with representatives from all units and efforts are made to perform the audits within 7 days of admission. The consultant pharmacist will perform this audit over the next three months. The consultant pharmacist will report audit findings to nursing administration and Director of Pharmacy. The consultant pharmacist, in consultation with the TCC (facility) Medication Error/Risk team will determine the ongoing audit frequency and duration after the initial three (3) month period. The medication transcription audit (see exhibit 22) will include a review for order omissions, dose omissions, duplicate medication orders, transcription errors, and allergies on MAR. The consultant pharmacist will report any irregularities to nursing administration and attending physician.	

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F 281	Continued From page 40	F 281		

29, 2014, at 2:40 p.m., in the conference room, confirmed "...always conceivable...the resident developed the DVT due to two missed doses of Lovenox..."

Resident #188 was admitted to the facility on March 22, 2014, with diagnoses including Rehabilitation, Dislocated Shoulder, Intracranial Hemorrhage, Subdural Hematoma, and Atrial Fibrillation.

Medical record review of the admission orders dated March 22, 2014, revealed "...hold Coumadin for one month, until cleared by neurosurgery..."

Medical record review of the Medication Record (MAR) dated March 25, 2014, revealed "...Coumadin (Warfarin Sodium) 2 mg TAB [tablet] Oral Every night @ [at] PM [night] for Blood Clotting Control, stop date of March 26, 2014..."

Medical record review of the Physician's Orders for March 25, 2014, revealed no order for Coumadin.

Medical record review of the MAR dated March 25, 2014, at 6:00 p.m., revealed LPN #2 administered a Coumadin 2 mg tablet to resident #188.

Medical record review of the Physician's Orders dated March 26, 2014, revealed "dc [discontinue] Coumadin order".

Review of the facility investigation dated March 27, 2014, revealed "...no Coumadin order in chart. Pt [patient] only had Coumadin order for

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 41	F 281		

3/25 - 3/26 but has been here since 3/22. RX [Pharmacy] status says it was ordered and canceled on 3/25 but still active 3/26..."

Review of the facility investigation dated April 1, 2014, revealed "...order entered in on wrong patient. Order was discontinued but did not disappear. Not sure why it did not go away. LPN gave one dose to wrong patient..."

Review of the facility investigation addendum (for the investigation initiated March 27, 2014), revealed "...placed order in computer under wrong pt [patient], so pharmacy called...canceled order..."

Interview with the Medical Director on September 29, 2014, at 2:30 p.m., in the conference room, confirmed "...aware of process issues...systemic problems..."

Interview with the DON on October 1, 2014, at 2:20 p.m., in the conference room, confirmed staff failed to follow accepted standards of practice for medication administration which resulted in resident #188 receiving Coumadin.

Resident #453 was admitted to the facility on February 10, 2014, with diagnoses including Rehabilitation, Aftercare for Healing Traumatic Fracture of Hip, Muscle Weakness, and Spinal Stenosis.

Medical record review of a physician's order dated February 12, 2014, revealed, "...Kcl [potassium chloride] 20 meq [milliequivalant] po [by mouth] x 1..."

Medical record review of the Medication Record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 42	F 281		

dated February 10, 2014, through March 10, 2014, revealed the physician's order was transcribed to the Medication Record for medication administration as "...Potassium Chloride 20 meq oral once a day at 0900 [9:00 a.m.] for abnormal labs..." Continued review of the Medication Record revealed the resident was administered Potassium 20 meq every day at 9:00 a.m., for a total of 22 days.

Medical record review of a 24 Hour Chart Check form revealed no documentation a 24 hour chart check was completed on February 13, 2014.

Review of a facility investigation dated March 6, 2014, revealed, "...Cause of Error...Order not signed off correctly...Daily chart check error...Order entry-Transcription Error..." Continued review revealed, "...Additional information and patient condition: was not put in as a 1x order therefore pt (patient) received daily..." Further review of the facility investigation dated and signed on March 14, 2014, by (RN) #8 revealed, "...Nursing Supervisor Comments/Actions and Suggestions to Prevent Occurrence in Future: The taking off and signing off were done in error and I can't find a 24 hour chart check...Breakdown in process..."

Review of a facility investigation with date received March 19, 2014, revealed, "...Was ordered as a one time medication but was not entered into computer as ordered. Pt received 22 daily doses before caught...Daily chart check was not done on evening-night shift that night. Order not signed off correctly. Discontinue date and time was not entered into computer to stop order...Incorrect order confirmation...transcription error..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 43	F 281		

Review of a facility investigation dated and signed by the CE/QA Nurse on March 19, 2014, revealed, "...What causes this occurrence?...Carelessness..." Continued review revealed, "...What do you suggest to prevent similar occurrences...I would think that if the med nurse has to override a med consistently they would check the order- hopefully before the 22nd dose..."

Interview with LPN #13 on September 29, 2014, at 3:44 p.m., in the conference room, confirmed LPN #13 was responsible for verifying the order for potassium after it was entered into the computer by the ward clerk. Continued interview confirmed LPN #13 did not ensure the order was transcribed correctly in the computer; and confirmed the order for potassium was written as a one time order, and the order was put into the computer as a daily dosing order. Further interview confirmed the resident received 22 total doses of potassium which were not ordered for the resident. Continued interview confirmed LPN #13 failed to follow the facility's policy for verification of physician's orders.

Resident #452 was admitted to the facility on January 24, 2014, with diagnoses including Intervertebral Disc Disorders, Thoracic Region, Urinary Tract Infection, Osteoarthrosis, Diabetes, and Hypertension.

Medical record review of the Physician's Recapitulation Orders dated January 24, 2014, revealed "...Percocet [Oxycodone] 325 mg-5 mg tab...every 6 hours prn [as needed] for pain..."

Medical record review of a Physician's Order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 44	F 281		

dated January 24, 2014, revealed "...Order clarification Percocet 5/325 1 q 6 [hours] prn for pain. may repeat in 1 [hour] if ineffective..."

Medical record review of a Physician's Order dated January 27, 2014, revealed "...Hydrocodone 5/325 po [by mouth] Q 8 [hours] scheduled [and] Q 6 [hours] PRN pain..."

Medical record review of a prescription dated January 27, 2014, revealed "...Oxycodone/APAP [narcotic pain reliever] 5/325...1 tab po Q 6 [hours] PRN pain...1 tab po Q 8 [hours] schedule..."

Medical record review of a Physician's Order dated January 31, 2014, revealed "...Discontinue hydrocodone order [and] continue oxycodone order per script..."

Medical record review of the Medication Record dated January 24, 2014, through January 31, 2014, revealed "...1/27/14 Hydrocodone...325 mg-5 mg 1 tab...oral every 8 hours for pain..." Continued review revealed the resident received the Hydrocodone scheduled every eight hours from January 27, 2014 through January 30, 2014.

Medical record review of the Medication Record dated January 24, 2014, through January 31, 2014, revealed "...Hydrocodone...325 mg-5 mg 1 tab...oral every 6 hours prn for pain..." Continued review revealed the resident received a total of five doses of the medication on January 27, and 28, 2014.

Medical record review of the Medication Record dated January 24, 2014, through January 31, 2014, revealed "...Percocet 325 mg-5 mg...oral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 45	F 281		

every 6 hours prn for pain..." Continued review revealed the resident received seven doses of Percocet January 24, 2014, through January 28, 2014, and three doses on January 30, 2014.

Review of the facility investigation dated February 4, 2014, revealed "...Event Date: 1/27/2014...Wrong Medication...MD [Medical Doctor #2] wrote order in chart for Hydrocodone 5/325 mg Q 8 hr and Q 6 hr-prn. [Medical Doctor #2] wrote a prescription for oxycodone 5/325 mg Q 8 hr and Q 6 hr-prn for the same patient on the [same] date. Prescription was not signed off and not noted if it had been faxed to pharmacy. Pt. received both medications. Script omission not caught on 24 hour chart check and not by the RN in charge..."

Interview with the CE/QA Nurse on September 25, 2014, at 10:30 a.m., in the conference room, confirmed the resident received the oxycodone and hydrocodone on January 27, 28, and 30th. Continued interview confirmed the nurse should have clarified the order, and it was discovered on January 31, 2014, by chart check because the NP wrote an order to discontinue the hydrocodone on this date.

Interview with the resident's physician on September 29, 2014, by telephone, at 3:50 p.m., confirmed the physician did not intend for the resident to have both percocet and hydrocodone.

Interview with RN #2 on September 30, 2014, at 8:20 a.m., by telephone, confirmed when new orders were written, the RN verifies the orders with the computer. Further interview confirmed RN #2 was not aware of the medication orders for hydrocodone and oxycodone, two separate pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 46	F 281		

medications.

Resident #454 was admitted to the facility on February 6, 2014, with diagnoses including Rehabilitation, Osteoporosis, Backache, Difficulty Walking, and Anemia.

Medical record review of a physician's order dated February 27, 2014, revealed "...Cefdinir [an antibiotic] 300 mg PO q12 [every 12] hours x 5 days..."

Medical record review of the Medication Record dated February 6, 2014, through March 6, 2014, revealed the order for the medication was entered to start on February 27, 2014, and entered with a stop date for March 6, 2014 (7 days later) instead of for March 4, 2014 (5 days later). Continued review revealed the resident received 5 extra doses of the antibiotic.

Review of a facility investigation signed and dated March 6, 2014, revealed, "...Cause of error...Order not signed off correctly...Daily chart check error...Order entry-transcription error..." Continued review revealed, "...Additional information and patient condition: No stop date entered into computer when order put in..."

Review of a facility investigation with date received March 17, 2014, revealed, "...No stop date entered into computer and patient got 5 extra days of medication= [equals] 5 doses...Chart check error...incorrect order confirmation...transcription error..."

Review of a facility investigation signed and dated by the CE/QA Nurse on March 17, 2014, revealed, "...What causes this occurrence?

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 47	F 281		

Carelessness...What do you suggest to prevent similar occurrences? Be careful..."

Interview with Ward Clerk #6 on September 29, 2014, at 2:24 p.m., in the conference room, confirmed the medication order for the antibiotic was transcribed incorrectly for administration for seven days instead of five days.

Telephone interview with RN #1 on September 29, 2014, at 3:50 p.m., confirmed the RN had completed the 24 hour chart check of the resident's medications. Continued interview confirmed the RN had not identified the transcription error during the 24 hour chart check, and had not followed the facility's policy for verification of physician's orders.

Resident #455 was admitted to the facility on February 24, 2014, with admitting diagnoses of Urinary Tract Infection, Pressure Ulcer Lower Back, Osteoporosis, and Osteoarthritis.

Medical record review of a physician's order dated March 3, 2014, revealed an order for Prilosec 20 mg (an antacid) daily.

Medical record review of the physician's orders dated March 8, 2014, revealed the physician reordered the Prilosec 20 mg daily.

Medical record review of the resident's MAR for March 2014 revealed the resident did not receive Prilosec from March 3 through March 8, 2014.

Review of a facility investigation dated March 13, 2014, revealed the order for Prilosec 20 mg daily was not discovered by LPN #9 or by RN #1 on the twenty-four hour chart check. Continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 48	F 281		

review revealed the cause for the error was listed as failure to read complete order sheet for orders.

Telephone interview with RN #1 on September 25, 2014, at 3:45 p.m., confirmed the order had been missed on the twenty-four hour check and the RN had not followed the facility Night Shift RN Checklist.

Interview with LPN #9 on September 25, 2014, at 4:30 p.m., in the conference room, confirmed the order for Prilosec had been missed and LPN #9 had not followed facility policy for accuracy in the transcription of physician orders.

Resident #456 was admitted to the facility on February 25, 2014, with diagnoses including Rehabilitation, Intracranial Hemorrhage following Injury, and Muscle Weakness.

Medical record review of a physician's order dated March 20, 2014, revealed "...Change Amitriptyline [an antidepressant medication] 10 mg po qhs [at bedtime] x 5 days then d/c..."

Medical record review of the Medication Record dated February 25, 2014, through March 25, 2014, revealed "...3/20/14 Amitriptyline Hydrochloride 10 mg tab...oral every night at bedtime...stop date 3/21/14..." Continued review of the Medication Record revealed the resident received the medication on March 20, 2014, and did not receive another dose of the medication until March 22, 2014, when the medication error was discovered, resulting in the resident missing one dose of the scheduled medication.

Review of a facility investigation signed and dated March 22, 2014, revealed, "...Receive orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 49	F 281		

error: Order put in wrong..." Continued review of the facility investigation revealed, "...Nursing Supervisor Comments/Actions to prevent Occurrence in Future: Will re-educate on order take off with stop dates included..."

Review of a facility investigation with date received April 1, 2014, revealed, "...chart check error...delay in processing order(s)...error in documentation...incorrect order confirmation...transcription error..."

Review of a facility investigation signed and dated by the CE/QA Nurse on April 7, 2014, revealed, "...What causes this occurrence? Put in computer wrong 5 day order put in for 1 day only start date 3/20 end 3/21..."

Interview with RN #6 on September 29, 2014, at 3:26 p.m., in the conference room, confirmed RN #6 completed the 24 hour chart check for the resident. Continued interview confirmed RN #6 did not identify the stop date for the order was transcribed incorrectly during the 24 hour chart check and failed to follow facility policy for 24 hour chart checks.

Resident #279 was admitted to the facility on April 5, 2014, with diagnoses of Rehabilitation, Aftercare for Healing Traumatic Fracture of Hip, Pneumonia, Urinary Tract Infection, and Diabetes Mellitus.

Medical record review of a physician's order dated April 10, 2014, revealed an order for Rocephin (an antibiotic) 1 Gram, IV (intravenous) now and daily for seven days.

Medical record review of the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 50	F 281		

medication record for April, 2014, revealed the order had not been transcribed to the MAR. Continued review of the resident's MAR revealed the Rocephin had not been given from April 10 through April 13, 2014 and four doses had been missed.

Review of a facility investigation dated April 17, 2014, revealed "...the order for the Rocephin 1 gram IV had not been transcribed...the cause listed...order was not processed...suggestion to prevent similar occurrences...RN must review orders thoroughly for accuracy, 24 hour chart check in place for a double check..."

Interview with RN #10 on September 25, 2014, at 11:17 a.m., in the conference room, confirmed the facility policy to ensure accuracy of transcription of orders had not been followed.

Telephone interview with RN #4 on September 25, 2014, at 1:35 p.m., confirmed could not recall the error, but if the medication was missed the transcription policy was not followed.

Telephone interview with ward clerk #3 on September 29, 2014, at 3:40 p.m., confirmed the order for the Rocephin IV on April 10, 2014, had not been transcribed and the transcription policy had not been followed.

Resident #111 was admitted to the facility on July 21, 2014, with diagnoses including Rehabilitation, Traumatic Fracture of the Hip, Osteoporosis, and Difficulty Walking.

Medical record review of the facility admission records dated July 21, 2014, revealed "Oxycodone (synthetic opioid pain medication) 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 51	F 281		

mg, 1 tab ORALLY, every 4 hours as needed, (for) 3 days, as needed, pain management." Further review revealed a duplicate Oxycodone order from a prescription detail (a paper subscription used for narcotics).

Medical record review of the MAR for July 2014, revealed "Oxycodone HCL oral every 4 hours prn for moderate pain." Continued review revealed the Oxycodone was given from July 25 through July 29, 2014, by four LPNs for five additional days and eleven additional doses.

Review of the facility investigation dated July 29, 2014, revealed "...medication was not discontinued after 3 days as ordered..." and resident #111 continued to receive Oxycodone 5 mg for five additional days and eleven additional doses.

Review of the facility investigation dated August 8, 2014, revealed "...order entry error- missed by RN sign off w (with) 24 hour chart check...". Further review revealed the report was signed by RN #8, PCC [Patient Care Coordinator].

Review of the facility investigation dated August 12, 2014, revealed "...medication not stopped after 3 days as ordered...Transcription error, chart check error, incorrect order confirmation..."

Review of the facility investigation dated August 13, 2014, revealed "...Rushing- there were 9 admissions that day for 1 WC & [and] 1 RN after 11:00..." Continued review revealed the review was conducted by the Clinical Educator/Quality Assurance Nurse.

Interview with RN #6 on September 29, 2014, at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 52 10:15 a.m., in the conference room, confirmed RN #6 signed off the admission orders and the 24 hour chart check. Continued interview confirmed "...we look back for 24 hours only, so if it gets missed, that's how it stayed on the MAR..." Further interview confirmed it is the RN's responsibility to verify the written orders with the computer. Interview with the RN #8 PCC on September 29, 2014, at 4:45 p.m., in the conference room, confirmed "...it was an input error..." Interview with the Director of Nursing and the Nurse Educator/Quality Assurance on September 29, 2014, at 2:18 p.m., in the conference room, confirmed the facility failed to follow physician's orders and medication administration policies for Resident #111. Resident #398 was admitted to the facility on July 21, 2014, with admitting diagnoses of Rehabilitation Process of Right Total Knee Replacement, Hypertension, Asthma, Difficulty in Walking, and Obstructive Sleep Apnea. Medical record review of the Physician's admission order dated July 22, 2014, revealed an order for "...diazepam [an antianxiety medication] 5 mg po twice daily as needed..." Medical record review of the MAR for July 21, 2014, through July 29, 2014, revealed diazepam 5 mg (milligrams) had been transcribed to be given routinely twice daily. Further review of the MAR revealed fifteen doses of the medicine had been given. Review of a facility investigation dated July 29,	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 53	F 281		

2014, revealed the medication order was for diazepam 5 mg BID (twice daily) PRN (as needed) and the order was transcribed into the computer as a routine scheduled order twice daily instead of as needed.

Interview with ward clerk #1 on September 29, 2014, at 2:50 p.m., in the Director of Nursing's office, confirmed the ward clerk had not followed facility policy for accuracy in the transcription of physician's orders.

Interview with RN #4 on September 29, 2014, in the conference room, at 3:40 p.m., confirmed the diazepam 5 mg had been transcribed incorrectly as a scheduled medication, and RN #4 missed the transcription error on the admission order and on the twenty four hour chart check.

Resident #105 was admitted to the facility on July 10, 2014, with diagnoses including Rehabilitation, Acute Renal Failure, Hypertension, Hypopotasemia, and Diabetes Mellitus.

Medical record review of the physician's orders dated July 10, 2014, revealed "...Potassium Chloride [electrolyte replacement for low blood levels of potassium] Extended Release Tablet, 10 milliequivalent [meq] every day..."

Medical record review of the Physician's Orders dated July 23, 2014, at 6:30 p.m., revealed "...KCL 20 meq po [every morning] [start in am] x [times] 3 days [edema]..."

Medical record review of the MAR revealed "...Potassium Chloride 20 meq oral once a day..." for three days only, July 24, 25, and 26, 2014.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 54	F 281		

Medical record review of the MAR revealed on July 24, 2014, Licensed Practical Nurse (LPN) #10 administered the 20 meq Potassium Chloride tablet and the 10 meq Potassium Chloride tablet for a total of 30 meq of Potassium Chloride.

Medical record review of the Physician's Orders dated July 25, 2014, at 8:23 a.m., revealed "...kcl [potassium chloride] on hold until 7/27 due to increase in meds..."

Review of the facility investigation dated August 14, 2014, revealed "...Pt already on KCL 10 meq daily, but new order for 20 meq x 3 days received. 10 meq not placed on hold so the pt received 30 meq on the first day of the three day order...WC did not notice the 10 meq order needed to be placed on hold..."

Interview with the DON on September 29, 2014, at 2:25 p.m., in the conference room, confirmed when a new order for the same medication was received, "...the old order has to be discontinued by the ward clerk..."

Interview with RN #7 Charge Nurse on September 29, 2014, at 5:45 p.m., in the conference room, confirmed "...the old order wasn't placed on hold..."

Interview with RN #8 PCC on September 30, 2014, at 8:50 a.m., in the ground floor nursing station, confirmed "...new medication orders supersedes old medication orders, they automatically dc the old order..."

Interview with the DON on October 1, 2014, at 2:20 p.m., in the conference room, confirmed the facility failed to follow the physician's orders and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 55	F 281		

did not follow accepted standards of practice for medication administration which resulted in Resident #105 receiving additional Potassium Chloride.

Resident #197 was admitted to the facility on July 24, 2014 with diagnoses of Trans Cerebral Ischemia, Esophageal Reflux, Hypothyroidism, Hypertension, and Depressive Disorder.

Review of the resident's admission orders dated July 24, 2014, revealed physician orders for Seroquel 200 mg every night, Sertraline 25 mg every night, Pravastatin 40 mg every night, and Resperidone 0.5 mg every night.

Medical record review of the MAR for July 2014, revealed the Seroquel 200 mg, Sertraline 25 mg, Pravastatin 40 mg, and Risperidone 0.5 mg were not administered on July 24, 2014.

Review of the facility investigation dated July 25, 2014, revealed the resident was not given Seroquel 200 mg, Sertraline 25 mg, Pravastatin 40 mg, and Risperidone 0.5 mg, due to a transcription error when the Ward Clerk transcribed the medication orders to another resident's MAR.

Interview with ward clerk #1 on September 29, 2014, at 2:50 p.m., in the DON's office confirmed "...was responsible for the medication error...not following facility policy for transcribing physicians orders correctly..."

Telephone interview with RN #5 on September 23, 2014, at 10:45 a.m., confirmed the RN had missed the medication omission on the initial chart check and on the twenty-four hour check

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 56	F 281		

and had failed to follow facility policy for checking accuracy in transcription of physician orders and the twenty-four hour check list.

Resident #23 was admitted to the facility on July 29, 2014, with diagnoses of Diastolic Heart Failure, Pressure Ulcer, Esophageal Reflux, and Muscle Weakness.

Medical record review of the resident's admission orders revealed an order for Restoril (a sleeping pill) 15 mg qhs (every night) PRN.

Medical record review of the resident's MAR revealed Restoril was on the MAR for July and August, 2014 to be given routinely every night and also at night, as needed. Continued review revealed the medication had been administered to the resident as a routine medication eight times from July 29, through August 5, 2014.

Review of a facility investigation dated August 7, 2014, revealed the order for Restoril was "...put into the computer as every night routine and an additional order was put in for Restoril 15 mg QHS PRN..." Continued review revealed the reason for the occurrence "...order not entered correctly upon admission..."

Interview with RN #8 on September 29, 2014, at 8:40 a.m., in the CE/QA nurse's office, confirmed the Restoril had been transcribed incorrectly as a PRN and scheduled medication and had not been transcribed per facility policy.

Interview with ward clerk #1 on September 29, 2014, at 2:50 p.m., in the DON's office, confirmed the ward clerk was aware of the medication error and had not followed facility policy for accuracy in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 57	F 281		

the transcription of physician's orders.

Telephone interview with RN #5 on September 29, 2014 at 4:25p.m., confirmed the RN did not recall the medication error, but confirmed if the order and the 24 hour chart check was signed by the RN and the error was not caught, the policy was not followed.

Resident #411 was admitted to the facility on August 2, 2014, with admitting diagnoses of Post Lumbar Laminectomy, Hypertension, Muscle Weakness, and Difficulty in Walking.

Medical record review of a physician's order dated August 5, 2014, revealed an order for a one-time dose of a Dulcolax Suppository (a stool softener) and a one-time dose for a bottle of Magnesium Citrate (a bowel cleansing agent) in the morning of August 6, 2014.

Medical record review of the MAR for August, 2014, revealed "... 08/05/14 Dulcolax 10 mg SUP suppository [Bisacodyl] rectal once a day for constipation...start date: 08/06/14...stop date: 08/28/14..." and "...08/05/14 Magnesium Citrate 1.75 GM [grams]/30 ml sol [Magnesium Citrate] oral once a day for constipation...start date: 08/06/14...stop date: 08/28/14..." Continued review revealed the Dulcolax and Magnesium Citrate had been initialed as held, due to resident refusal, on the morning of August 6, and had been initialed as given on August 9, 10, and 25, 2014, for a total of three doses of each medication.

Review of a facility investigation dated September 4, 2014, revealed "... med order was Dulcolax Supp. X I in am, order was processed as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 58	F 281		

Dulcolax Supp. PR [rectally] daily @ 9:00... this was on emar [electronic medication administration record] x 23 days but pt. refused all but three doses...[MDS RN #11] notified me of error on 8/28/14 [date of discharge]...[there was total of 2 extra doses given], cause of occurrence: order not processed correctly; Prevent similar occurrences: need to read order and 24 hour chart checks already in place to help avoid these errors..."

Telephone interview with RN #4 on September 29, 2014, at 9:35 a.m., confirmed the one time order for the Ducolax suppository and Magnesium Citrate was missed on the twenty-four hour check on August 5, 2014, and RN #4 had failed to follow the Night Shift RN Checklist policy to verify accurate transcription of physician's orders.

Interview with RN #6 on September 29, 2014, at 10:10 a.m., in the conference room, confirmed the order for the one-time dose Dulcolax suppository and a one-time dose of magnesium citrate were missed because the LPN had not followed the Charge Nurse policy for accurate transcription of a physician's order.

Interview with ward clerk #1 on September 29, 2014, at 2:50 p.m., in the Director of Nursing's office, confirmed the ward clerk was aware of the medication error and had not followed facility policy for accurate transcription of physician's orders.

Resident #238 was admitted to the facility on August 14, 2014, with diagnoses including Aortocoronary Bypass, Dysphagia, Muscle Weakness, Difficulty in Walking, Diabetes,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 59	F 281		

Hypertension, and Hyperlipidemia.

Medical record review of the Physician Orders dated August 2014 revealed an order "...August 14, 2014, Furosemide [diuretic medication] 20 mg tab oral daily @ [at] 6 am for edema..."

Medical record review of the Physician's Orders dated August 19, 2014 revealed order "...Lasix [furosemide] 40 mg po now and give another 20 mg at 6 p.m...Increase Lasix in am to 40 mg daily and 20 mg q [every] pm..."

Medical record review of the Physician Telephone Orders dated August 20, 2014 revealed "...D/C [discontinue] Lasix..."

Medical record review of the Medication Record for August 2014, revealed the resident received Furosemide 40 mg on August 21, 2014, and August 22, 2014, two days after the medication was discontinued.

Medical record review of the Medication Record for August 2014, revealed the resident did not receive Lasix 40 mg po now as ordered on August 19, 2014.

Review of the facility investigation with date prepared August 22, 2014, revealed "...drug name Lasix...The medication order: D/C Lasix...Type of error wrong dosage...Cause of error order not signed off correctly...Lasix was discontinued...What do you suggest to prevent similar occurrences? Review all orders when a change is made to ensure accuracy...Additional comments: Admission orders had generic name and NP wrote for Brand name to be discontinued. WC [ward clerk] and RN did not catch generic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 60	F 281		

name..."

Review of the facility investigation dated August 29, 2014, revealed "...Chart Check Error, Did Not Read Drug Label, Incorrect Order Confirmation, Transcription Error..." Continued review revealed "...Admission orders listed meds in generic forms. NP stopped it but called by brand name...RN did not catch the generic form of the drug when signing off orders and the 24 hour chart check did not catch it neither..."

Medical record review of the 24 Hour Chart Check form for the month of August revealed the 24 hour chart check was done on August 21, 2014, and the RN did not identify the order to discontinue Lasix on August 20, 2014.

Interview with the Clinical Educator/Quality Assurance Nurse on September 25, 2014 at 1:41 p.m., in the conference room revealed "...The resident admission orders written were written on August 14, 2014. At that time the resident was on Furosemide...[NP #2] came in on August 19, 2014 and wrote an order for Lasix 40 mg now. The [NP] also increased Lasix to 40 mg daily... [LPN #3] gave the doses of Furosemide to the resident...[Ward Clerk #5] did not know that Lasix and Furosemide are the same medication so the Furosemide remained on the Medication Record..." Further interview with the CE/QA Nurse revealed "...[RN#11] Charge Nurse was supposed to compare the written orders with the computer...The nurse did not do that..." Continued interview revealed RN #6 during review of the MAR discovered the medication error on August 22, 2014, at 10:44 p.m., two days later.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 61 Interview with the NP #1 on September 29, 2014 at 11:00 a.m., in the conference room, confirmed the facility failed to follow their policy on medication administration and to perform an accurate 24 hour chart check of resident medications. Interview with Ward Clerk #5 on September 29, 2014 at 2:45 p.m., by telephone, revealed unaware of medication error regarding now dose of Furosemide. Continued interview revealed "...No one told me about the error...I take the orders off then put the order in the computer then place the chart in the nurse's box and the nurses recheck it..." Interview with the CE/QA Nurse on September 29, 2014, at 4:47 p.m., in the conference room, confirmed RN #5 performed the twenty- four-hour chart check and failed to verify the medication order, follow the medication administration policy, and follow the twenty hour night shift check list. Telephone interview with RN #2 on September 30, 2014, at 8:19 a.m., revealed "...When the Furosemide was discontinued both the Furosemide and Lasix was both listed on the MAR...I looked at the Lasix order on August 20, 2014 to discontinue Lasix. I didn't discontinue furosemide...I just looked at the one medication [Lasix]. I didn't know it under two different names...I knew the two names. I just looked up Lasix...I saw the Lasix was discontinued but didn't check for Furosemide...The medication error was brought to my attention the next day by [RN #3 PCC]..." Continued interview confirmed the facility failed to follow the medication administration policy.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 62 Interview with the Administrator on September 30, 2014, at 10:12 a.m., in the conference room, revealed the Administrator was aware of medication errors. Continued interview revealed the Administrator stated the medication errors were more of an individual problem, and "...have been handled on an individual basis..." Further interview revealed the Administrator stated there was a problem in the three step process of transcription and verification of physician's orders (#1. The ward clerk transcribing physician's orders correctly from the paper orders into the electronic MAR, #2. The RN checking to verify the orders were correct, and #3. The Night Shift RN Checklist double-checking for any transcription errors). Interview with the DON on September 30, 2014, at 11:10 a.m., in the conference room, revealed "...We have a problem with the three step process regarding taking off orders...it is a combination of things...I don't think we have come down to a clear answer..." Continued interview confirmed the facility failed to verify the accuracy in the transcription of the physician's orders to the electronic MARs. The Immediate Jeopardy was effective from February 12 through October 1, 2014, and was removed onsite on October 2, 2014. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the surveyors through review of documents, staff interviews, and observations conducted onsite on October 2, 2014. The surveyors verified the	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 63 allegation of compliance by: 1. Review of the facility's in-service records to ensure nursing staff were educated regarding changes for medication administration which included the implementation of paper Medication Administration Records (MARs). Review included the facility's plan of action to ensure all nurses were educated on the new system before being allowed to work a shift (coordinated by the Director of Nursing), and the facility's plan for education for nurses who were not scheduled to work or who were on vacation or Family Medical Leave. 2. Verification of the new medication administration system by the facility which included discontinuation of the Electronic Medication Administration Record (EMAR) and implementation of paper Medication Administration Records. Verification included review reconciling new physician's orders and the correct reconciliation to the new paper MARs. 3. Verification through interview with the Director of Nursing and Medical Director, and review of facility documentation all current resident's medication orders were accurately transcribed to paper MARs. 4. Verification through interview with the Administrator, and review of facility documentation the facility's identification of eight transcription errors during the facility's audit of all current resident's medication orders. Verification through interview with the Medical Director of immediate intervention to assess resident's status after identification of the error, and provide clarification orders where needed. 5. Review of a random sample of active resident charts to verify the accurate transcription of new physician's orders to the paper MARs. Review of	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 64 random sample of active resident charts for the completeness and accuracy of 24 hour chart checks. 6. Verification through observation in both nursing stations new orders were being transcribed by Registered Nurses only. 7. Verification through interviews with nine Registered Nurses, seven Licensed Practical Nurses, and three Ward Clerks/Certified Nursing Assistants to determine the comprehension gained through in-services conducted by the Director of Nursing regarding the changes and implementation of the facility's new transcription and verification procedures. 9. Verification through interview with the Administrator, Medical Director, Chief Nursing Officer, Risk Management Team, Director of Nursing, and Director of the Pharmacy Vendor of their participation in risk management meeting to address the system changes with medication administration. 10. Verification through observation and interview with ward clerks and registered nurses the facility discontinued the process of entering physician orders electronically by the ward clerks. 11. Verification through observation faxed medication orders were reconciled in real time. Non-compliance continues at an "F" level for monitoring the effectiveness of corrective actions and evaluation of monitoring by the Quality Assurance Committee. The facility is required to submit a plan of correction. c/o #34603	F 281		
F 309 SS=L	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	10/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 65 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, review of facility investigations, and interview, the facility failed to prevent systemic failures of inaccurate medication transcription; failed to verify physician orders for medication; and failed to identify inaccurate medication transcription on 24 hour chart checks by licensed nurses to ensure medication orders were followed, resulting in medication errors. The facility's failure placed sixteen residents (#262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238) of twenty-four residents reviewed for medication errors in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death). The facility's failure was likely to place any resident who received medications at risk for immediate jeopardy. The Administrator, Medical Director, Chief Medical Officer/In House Legal Counsel, Chief Nursing Officer, and Director of Nursing were informed of the Immediate Jeopardy on September 30, 2014, at 4:00 p.m., in the conference room.	F 309	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The medication errors of residents #262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238 have been additionally reviewed by the Transitional Care Center (TCC) (facility) Medical Director and Nursing Leadership Team on October 21, 2014. This team (created on October 7, 2014) meets at 8:00am Monday through Friday and is attended by the TCC Administrator, Director of Nursing (DON), Patient Care Coordinators (PCCs), Clinical Educator (CE), and Medical Director at her discretion or as requested. During this meeting, a general review of medication occurrences including medication errors and ensuring appropriate notification has been completed is discussed (see exhibit 7). Since it was created the Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and Medical Director have attended daily to ensure the Nursing Leadership Meeting is accomplishing its function. None of these residents suffered a prolonged or permanent condition from the noted medication error. Each resident was discharged as indicated below. #262 to Blount Memorial Hospital on July 25, 2014. She discharged from the hospital to a second skilled nursing facility from which she later discharged to home in good condition. #457 to home on March 31, 2014 #453 to home with Home Health on March 24, 2014 #454 to home with Home Health on March 19, 2014 #455 to home with Home Health on April 12, 2014 #456 to an Intermediate Care facility on April 9, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 66 The Immediate Jeopardy was effective February 12, 2014 through October 1, 2014. An extended survey was conducted on September 30, to October 2, 2014. Substandard Quality of Care was cited at F309-L. The facility submitted an Acceptable Allegation of Compliance to the survey team on October 2, 2014. The survey team verified the actions taken by the facility removed the jeopardy on October 2, 2014. Noncompliance continues at the "F" level. The findings included: Review of facility policy Medication Administration: General Guidelines, no date, revealed "...Procedures: 2) Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnoses or condition, the physician is contacted for clarification prior to the administration of the medication. This interaction with the physician is documented in the nursing notes and elsewhere in the medical record as appropriate." Review of facility policy Charge Nurse Review, dated June, 2012, revealed "...C) 2: Reviewing medication cards for completeness of information, accuracy in the transcription of physician orders, and adherence to stop order policies..." Review of Night Shift RN (Registered Nurse) Checklist, undated, revealed "...3: Check charts	F 309	#279 to home with Home Health on May 8, 2014 #111 to home with Home Health on August 10, 2014 #398 to home with Home Health on August 7, 2014 #105 to home with Home Health on August 14, 2014 #197 to home with Home Health on August 8, 2014 #23 to home with Home Health on September 4, 2014 #411 to home on August 29, 2014 #238 to home on September 30, 2014 The Medical Director determined for resident #188, after her additional review of the medical record, the medication dispensing system reports, and pharmacy records, that the resident did not receive Coumadin as documented by the nurse. The nurse entry was inaccurate. This staff member no longer works at TCC (facility). In complete review of chart, there was NO order for Coumadin 2 mg to be given to the resident. However, an electronic request was sent to pharmacy for Coumadin 2 mg. Pharmacy rejected the order due to admission order clarification for "hold Coumadin". They notified TCC (facility) of rejection of order. The pharmacy (which generates Coumadin orders per protocol) did not generate a Coumadin order for this resident. There was no Coumadin withdrawn from medication dispensing system profile assigned to this resident. Resident #188 was discharged home to Assisted Living with Hospice to follow on April 11, 2014. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;	

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	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 309	Continued From page 67 after midnight (24 hour chart checks). If any new medications ordered, verify they were on the MAR (Medication Administration Record)..." Resident #262 was admitted to the facility on July 23, 2014, with diagnoses of Pneumonia, Acute Renal Failure, Rehabilitation, Atrial Flutter, and Muscle Weakness. Medical record review of a Medication Record (MAR - record for documenting medication administration) for July 2014, revealed on July 24, 2014, at 2100, the resident was given Seroquel (an antipsychotic medication) 200 mg, Sertraline (an antidepressant medication) 25 mg, Pravastatin 40 mg (an anti-cholesterol medication), and Risperidone 0.5 mg (an antipsychotic medication). Review of the Physician's orders for resident #262 for July 23 through July 25, 2014, revealed no orders for Seroquel 200 mg, Sertraline 25 mg, Pravastatin 25 mg, or Resperidone 0.5 mg. Medical record review of a nurse's note dated July 25, 2014, revealed "...05:30 unit secretary found med [medication] error as...was putting in other orders on another pt [patient]. Pt. had 3 meds that were not her orders. VS [vital signs] B/P [blood pressure, normal blood pressure is 120/80]...88/53...Pt very sleepy hard to arouse... [Physician] notified, orders noted..." Medical record review of a nurse's note date July 25, 2014, at 9:45 a.m., revealed the nurse started and intravenous access to administer fluids of normal saline at 60 ml/hr (milliliters per hour), as ordered by the physician, to treat hypotension (low blood pressure).	F 309	All residents in the TCC (facility) were considered to have the potential to be affected. The Electronic Medication Administration Record (E-MAR), Electronic Treatment Administration Record (E-TAR), and Electronic Physician Order Entry (E-POE) system were abandoned immediately on September 30, 2014, returning to a hand-written, paper-based MAR, TAR, and physician order system, effective October 1, 2014. On September 30, 2014 through October 1, 2014, charts and MARs of 100% of the current residents (68) were reviewed during our conversion from E-MAR to paper MAR. In the process, the records were analyzed for any medication errors by the Medical Director who was on site through the entire conversion process. Our initial review identified 7 residents (8 errors) who we thought were affected. However, on further review, one resident (MR# 425745) had previously been notified of the error and another (one of two on MR# 448221) was found not to be an error. The following residents were affected: Resident MR# 475365: Omission of medication on September 14, 2014 Resident MR# 483234: Transcription error on September 18, 2014 Resident MR# 689434: Transcription error on September 25, 2014 Resident MR# 791005: Transcription error on September 23, 2014 Resident: MR# 524029: Transcription error on September 5, 2014 Resident MR# 448221: Transcription error on September 15, 2014 Starting September 30, 2014, additional Registered Nurses (RNs), employed by Parent Hospital (Blount Memorial) were assigned to the TCC (facility) to complete the following tasks: • Transcribe all physician orders for every current resident to a hand-written MAR and/or TAR on September 30, 2014 for use on October 1, 2014	

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	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 309	Continued From page 68	F 309	• Verify (2 RNs) accuracy of all physician orders for every current resident to a hand-written MAR and/or TAR after transcription completed on October 1, 2014. • Provide every 12 hour chart checks to include review of all MARs, TARs, and new physician orders effective October 1, 2014. This process is ongoing. • Administer all medications under the purview of two licensed nurses (RN or Licensed Practical Nurse (LPN)) effective October 1, 2014. This process is ongoing. Initial education in this process was completed by the CNO on September 30, 2014 during a face to face educational session with all RNs and LPNs present that shift. For the subsequent shifts, the DON reviewed the Allegation of Compliance and reviewed the process for transcribing and verifying MARs and TARs with each shift's RNs and LPNs (see exhibit 16). The TCC (facility) Medical Director was on site on September 30, 2014 through October 1, 2014 during the above referenced transcription and verification process to provide clarity to any uncertain physician order or questionable medication or treatment. The "Medication Administration" policy (see exhibit 17) was a new policy that was created on October 22, 2014 by the Associate Nurse Executive of the parent hospital with approval by the Interim DON, CNO, and Medical Director. This policy describes the transcription and verification process and was implemented October 25, 2014. Educational in-service on this policy was conducted by Interim DON, Interim CE, and PCCs from October 22, 2014 through October 25, 2014, and included all RNs, CNAs, LPNs, and WCs. Two staff members were on vacation during this in-service and completed their education to this policy by October 27, 2014. New or contract staff will receive education to this policy (see exhibit 17) as part of their new employee orientation packet. This educational material will be updated as policy changes occur by the CE.	

Medical record review of the nurses note dated July 25, 2014, at 2:45 p.m. revealed, "...reported to [family members] medications given to pt last night. Pt family spoke with [NP] and CE/QA nurse [Clinical Educator/Quality Assurance Nurse], voiced concerns regarding medications. Requested pt [patient] be sent to ER [Emergency Room] for evaluation..."

Medical record review of a Physician's progress note dated July 25, 2014, at 1:50 p.m., by NP #1, revealed "...Called to room by [RN] to discuss with [family member] some follow up concerns. [Family member] requests discussion out of room...voices concern Re: [regarding] jerking movements and effects of Seroquel & [and] Risperdal on these movements...In room patient awake - [family] stating not like [normal]. Counseled them on expected side effects Seroquel & Risperdal, todays lab results to include tx [treatment] for elevated potassium and use of IVF [intravenous fluids] for management/correction of hypotension. Discussed option of hospitalization for more aggressive evaluation of myoclonus [seizure activity] to include possibility of further imaging & neurology eval [evaluation]...somnolence [excessive sleepiness] significantly improved myoclonus now exacerbated [made worse]..."

Medical record review of a facility Discharge Summary dated July 25, 2014, revealed "... Pt discharged to hospital, dx [diagnosis]: accidental overdose..."

Review of the facility investigation initiated July 24, 2014, revealed resident #262 was given Seroquel 200 mg, Sertraline 25 mg, Pravastatin

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	445404	A. BUILDING _____ B. WING _____	10/02/2014

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BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 309	Continued From page 69 40 mg, and Risperdal 0.5 mg one time. Further review of the facility investigation revealed "...Pharmacist contacted for additional...orders from one new admission were put on a pt. that had already been there x 2 days...WC [ward clerk] was still in a new admission profile & went into [resident #262] profile did not switch back to the new admission profile, new admission meds put in [resident #262's] profile..." Interview with RN #5 on September 23, 2014, at 8:45 a.m., by telephone, revealed the ward clerk transcribed a new admission's Seroquel, Sertraline, Pravastatin, and Risperdal (Risperidone), from the computer screen of resident #197 into resident 262's MAR at 9:44 p.m., on July 24, 2014. The order was discovered during the 24 hour check by RN #5 at 4:00 a.m., and the Physician was notified of the medication error. Orders were received to watch the resident and take vital signs every 2 hours. RN #5 stated the resident became more somnolent and not arousable later in the morning, the blood pressure was slightly low at 100/62. RN #5 gave report in the morning shift change to Licensed Practical Nurse (LPN) #7 and also to PCC (Patient Care Coordinator) #8. RN #5 completed a facility investigation report. Interview with charge RN #7 on September 23, 2014, at 8:55 a.m., in the conference room, revealed RN #7 assessed the resident with LPN #7 and PCC #8 on the morning of July 25, 2014, received report from LPN #7 about the medication error the previous night, performed a sternal rub with response from the resident, but the resident did not open eyes. RN #7 went in later to start an IV (intravenous access for fluid and medication administration) with LPN #7,	F 309	The CE will also be responsible for educating current RNs, LPNs, CNAs, and WCs of policy changes when they occur. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; All RNs and LPNs were educated to the revised transcription and verification process for MARs and TARs and the Medication Administration Policy (see exhibit 4). Educational in-service on this policy was conducted by Interim DON, Interim CE, and PCCs from October 22, 2014 through October 25, 2014, and included all RNs, CNAs, LPNs, and WCs. Two staff members were on vacation during this in-service and completed their education to this policy by October 27, 2014. New or contract staff will receive education to this policy (see exhibit 17) as part of their new employee orientation packet. This educational material will be updated as policy changes occur by the CE. The CE will also be responsible for educating current RNs, LPNs, CNAs, and WCs of policy changes when they occur. Beginning on October 17, 2014 TCC (facility) now receives a printed MAR from the pharmacy every day for the next 24 hour period. These MARs are reviewed by two RNs for accuracy prior to use for medication pass by TCC (facility) nurse. On October 10, 2014, Hospital Quality Management Department began performing audits of 100% of the facility's residents each day to ensure that the following processes are completed: • Verification that 2 RNs have deemed all physician orders accurate for every current resident • 12 hour chart checks are completed on every resident each shift including review of all MARs, TARs, and new physician orders • Two licensed nurses have reviewed every medication administered to every resident If the Quality Management Department finds deficiencies during their audits, they communicate these to the DON.	

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	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 70 started the IV in the right forearm, and administered normal saline at 60 cc (cubic centimeters)/hr. (per hour) per the order from NP #1 to treat the resident's hypotension. Interview with LPN #8 on September 23, 2014, at 9:31 a.m., by telephone, confirmed the Seroquel 200 mg, Sertraline 25 mg, Pravastatin 40 mg, and Risperdal 0.5 mg were administered by LPN #8 in error to the resident on July 24, 2014, at 9:00 p.m. Interview with PCC (patient care coordinator) #8 on September 23, 2014, at 9:50 a.m., in the conference room, revealed RN #7 had spoken about the resident's medication error and overall condition around 7:00 a.m., on July 25, 2014, and had notified NP #1 when the NP arrived at around 7:45 a.m. The PCC assessed the resident with LPN #7 and charge RN #2 and found the resident to be unarousable. Interview with charge RN #7 on September 23, 2014, at 10:56 a.m., in the conference room, revealed the RN #7 had assessed the resident at shift change on the morning of July 25, 2014, found the resident's mental status to be more confused, called NP #1, received orders for a chest x-ray, an ECG (electrocardiogram) and to start IV fluids of Normal Saline 1 liter at 60cc/ hour to treat hypotension. Resident #457 was admitted to the facility on March 14, 2014, with diagnoses including Acute Venous Embolism and Thrombosis of Lower Extremity, and Fractured Hip. Medical record review of the Hospital Discharge Medication List dated March 14, 2014, revealed	F 309	Deviations from these practices as of October 27, 2014 will result in employee re-education and/or disciplinary action by the DON. Beginning October 17, 2014, the WCs began faxing every new physician order to the pharmacy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. The TCC Medication Error/Risk Team began on October 6, 2014 to evaluate compliance with the process defined in the policy "Medication Administration" (see exhibit 17) each time a medication error occurs, in addition to reviewing medication error rates in the weekly meeting. This team meets every Monday at 1:30pm and includes the TCC Medical Director, TCC Administrator, Hospital CMO, Hospital CNO, Consultant Pharmacist, Hospital Associate Nurse Executive, TCC DON, TCC PCC, TCC CE, Hospital Risk Manager, and Hospital Quality Management Director. In addition to other responsibilities (see exhibit 13), the Medication Error Team/Risk Team reviews all medication occurrence reports (see exhibit 6), negative trends identified from the quality database analysis of these reports, and the Hospital Quality Management verification, chart check, and medication transcription audit (see exhibit 22) results weekly. The team will also discuss any Safety Hotline calls made concerning medication errors or medication administration processes at TCC. This Hotline is used to report conditions affecting clinical resident safety or quality of care issues including medication errors or concerns. Calls may be left anonymously or callers may leave contact information. The Hospital Safety Hotline phone number is posted in staff work areas. Beginning October 27, 2014, a systematic plan for audit frequency will be followed (see exhibit 21). During the consultant pharmacist's weekly visit, the pharmacist will audit at least 10 residents' MARs for accuracy and completeness of profile.	

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	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 309	Continued From page 71 "...Enoxaparin [a medication to prevent blood clots]...0.4 ml [milliliters], subcutaneous, every 24 hours..." Medical record review of the Physician's Recapitulation Orders dated March 14, 2014, revealed "...Enoxaparin...40 mg/0.4 ml sol [solution] give 0.4 ml...subcutaneous once a day for blood clotting control..." Medical record review of the Medication Record dated March 14, 2014, through March 20, 2014, revealed the days for administration of the medication was indicated as every other day and and the resident did not receive Enoxaparin 40 mg subcutaneous on March 15 and March 17, 2014. Medical record review of a Physician's Order dated March 18, 2014, revealed "...Vascular US [ultrasound] RLE [right lower extremity] Dx: [diagnosis] warmth, edema [swelling]... Dx: chills, warm, swollen RLE..." Medical record review of a Diagnostic Report dated March 19, 2014, revealed "...Exam...Lower Venous Right...Clinical: RLE Edema and Warmth...Findings...Significant nonocclusive thrombus [blood clot] is seen within the right posterior tibial and peroneal veins...Impression: significant nonocclusive thrombus below the knee within the right peroneal and posterior tibial veins..." Medical record review of a Physician's Progress Note dated March 19, 2014, revealed "...results RLE doppler show nonocclusive thrombus below knee [within] right peroneal [and] post tibial veins. Pt has had erythema [redness]/edema x [times] 2	F 309	This number was determined based on an average admission volume of about 20 residents per week. The residents audited are chosen with representatives from all units and efforts are made to perform the audits within 7 days of admission. The consultant pharmacist will perform this audit over the next three months. The consultant pharmacist will report audit findings to nursing administration and the Director of Pharmacy. The consultant pharmacist, in consultation with the TCC (facility) Medication Error/Risk team will determine the ongoing audit frequency and duration after the initial three (3) month period. The medication transcription audit (see exhibit 22) will include a review for order omissions, dose omissions, duplicate medication orders, transcription errors, and allergies on MAR. The consultant pharmacist will report any irregularities to nursing administration and attending physician.	

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	445404	A. BUILDING _____ B. WING _____	10/02/2014

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F 309	Continued From page 72	F 309		

days..."

Medical record review of a Physician's Order dated March 19, 2014, revealed "...lovenox [Enoxaparin] 1 mg/kg [kilogram] SQ [subcutaneous] every 12 hours clarified with pharmacy to give lovenox 100 mg sq q 12 hours [every 12 hours]...give additional 60 mg lovenox to equal to 100 mg lovenox today..."

Review of the facility investigation dated March 20, 2014, revealed "...Error when entering order. clicked frequency options and entered every 2 days...suggest to prevent similar occurrences? Read order thoroughly recheck after entered for accuracy..."

Review of the facility investigation dated March 21, 2014, revealed "...Event Date: 3/14/2014...Order entry error off admission orders from [named hospital]. WC [ward clerk] changed the frequency of the med [medication] dosing which should not have been adjusted. Nurse did not notice the change in time frequencies...Medication involved: Enoxaparin [Lovenox]..."

Medical record review of the physician's order dated March 21, 2014, revealed "...Continue Lovenox 100 mg SQ Q 12 h (hour)...for new onset DVT [Deep Vein Thrombosis]..."

Interview on September 29, 2014, at 8:30 a.m., with the CE/QA Nurse in the conference room, confirmed the Lovenox order was transcribed incorrectly, entered as every other day, and the facility failed to administer the medication as ordered to Resident #457 on March 15 and 17, 2014. Continued interview confirmed the ward

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	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 73	F 309		

clerk entered the order incorrectly with the frequency of every other day.

Interview with RN #6 on September 29, 2014, at 9:10 a.m., in the conference room, confirmed was responsible for verifying the order of Lovenox and failed to verify the order for accuracy. Continued interview confirmed "...probably had a lot of admissions and may have been interrupted...resident was admitted sometime around 4:00 p.m...most admissions come in between 5:00 p.m. and 7:00 p.m..." Continued interview confirmed signed the twenty-four hour chart check on March 15, 2014, and did not identify the error.

Interview with NP #1 on September 29, 2014, at 11:00 a.m., in the conference room, confirmed it would be possible the missed doses contributed to the development of the DVT.

Resident #188 was admitted to the facility on March 22, 2014, with diagnoses including Rehabilitation, Dislocated Shoulder, Intracranial Hemorrhage, Subdural Hematoma, and Atrial Fibrillation.

Medical record review of the admission orders, dated March 22, 2014, revealed "...hold Coumadin [a medication to prolong blood clotting time] for one month, until cleared by neurosurgery..." Further review revealed Ward Clerk #4 completed transcription of the orders on March 22, 2014, at 5:50 p.m., and RN #4 signed off as reviewing the orders on March 23, 2014, at 12:27 a.m.

Medical record review of the 24-Hour Chart Check revealed the signature of RN #4 on March

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	445404	A. BUILDING _____ B. WING _____	10/02/2014

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F 309	Continued From page 74	F 309		

23, 2014 at 12:29 a.m.

Medical record review of the MAR dated March 25, 2014, revealed an order "...Coumadin 2mg [milligram] TAB [tablet](Warfarin Sodium) Oral Every night @ [at] 6pm for Blood Clotting Control, stop date of March 26, 2014..."

Medical record review of the Physician's Orders for resident #188 revealed no order for Coumadin on March 25, 2014.

Medical record review of the MAR dated March 25, 2014, at 6:00 p.m., revealed LPN #2 administered a Coumadin 2 mg tablet to resident #188.

Medical record review of the Physician's Orders dated March 26, 2014, revealed "dc [discontinue] Coumadin order."

Review of the facility investigation dated March 27, 2014, revealed "...no Coumadin order in chart. Pt only had Coumadin order for 3/25-3/26 but has been here since 3/22. RX [Pharmacy] status says it was ordered and canceled on 3/25 but still active 3/26..." Continued review revealed event date of March 25, 2014.

Review of the facility investigation dated April 1, 2014, revealed "...order entered in on wrong patient. Order was discontinued but did not disappear. Not sure why it did not go away. LPN gave one dose to wrong patient..."

Record review of the facility investigation addendum, dated March 26, 2014, revealed "...placed order in computer under wrong pt, so pharmacy called...canceled order..."

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	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 75	F 309		

Interview with the Clinical Educator/Quality Assurance Nurse on September 25, 2014, at 10:55 a.m., in the conference room, confirmed responsibilities include completion and investigation of the facility investigation. Further interview confirmed "...the whole thing was done incorrectly, the drug, the dose, and the frequency..."

Interview with the LPN #2 on September 29, 2014, at 8:50 a.m., by telephone in the conference room, confirmed administering the Coumadin 2 mg tablet on March 25, 2014. Further interview confirmed overriding the Pyxis [computerized medication dispensary] to obtain the Coumadin. Continued interview confirmed "...I was never told I made a med error..."

Interview with NP #1 on September 29, 2014, at 11:20 a.m., in the conference room, confirmed notice of medication error on March 26, 2014. Further interview confirmed "...I don't review all of the EMARS [Electronic Medication Administration Record] or I would never get done...that is a significant med error..."

Interview with RN PCC #3 on September 29, 2014, at 5:30 p.m., by telephone, confirmed the Coumadin investigation was conducted with interviews with Ward Clerk #4 and RN #4 "...re-educated on comparing the computer and paper orders..." Further interview confirmed the interviews and re-education were not documented "...we only document if they are in the disciplinary process..."

Interview with Pharmacy Consultant #1 on September 30, 2014, at 9:30 a.m., in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 76	F 309		

conference room, confirmed the pharmacy notified the facility of the Coumadin dose due to "...the INR (International Normalized Ratio) results [lab test for patients taking Coumadin]...if we had not received the INR, we would not have caught it...would have continued to receive it...yes...and I consider it a significant med error..."

Interview with RN #4 on September 30, 2014, at 5:25 p.m., by telephone, confirmed signing off the admission orders on March 22, 2014, after computer entry by Ward Clerk #4. Further interview confirmed RN #4 signed the 24 Hour Chart Check at 12:29 a.m., on March 23, 2014, and at 12:20 a.m., on March 26, 2014. Further interview confirmed "...kind of remember it..." and RN #4 confirmed had no re-education on medication errors.

Resident #453 was admitted to the facility on February 10, 2014, with diagnoses including Rehabilitation, Aftercare for Healing Traumatic Fracture of Hip, Muscle Weakness, and Spinal Stenosis.

Medical record review of a physician's order dated February 12, 2014, revealed, "...Kcl [potassium] 20 meq [milliequivalant] po (by mouth) x [times] 1..."

Medical record review of the Medication Administration Record dated February 10, 2014, through March 10, 2014, revealed the physician's order was transcribed to the MAR as "...Potassium Chloride 20 meq oral once a day at 0900 [9:00 a.m.] for abnormal labs..." Continued review of the MAR revealed the resident was administered Potassium 20 meq every day at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 77	F 309		

9:00 a.m. for a total of 22 days.

Review of facility investigation dated March 6, 2014, revealed, "...Cause of Error...Order not signed off correctly...Daily chart check error...Order entry-Transcription Error..." Continued review revealed, "...Additional information and patient condition: was not put in as a 1x order therefore pt received daily..." Further review of the facility investigation dated and signed on March 14, 2014, by RN #8 revealed, "...Nursing Supervisor Comments/Actions and Suggestions to Prevent Occurrence in Future: The taking off and signing off were done in error and I can't find a 24 hour chart check...Breakdown in process..."

Review of facility investigation with date received March 19, 2014, revealed, "...Was ordered as a one time medication but was not entered into computer as ordered. Pt received 22 daily doses before caught. Daily chart check was not done on evening-night shift that night. Order not signed off correctly. Discontinue date and time was not entered into computer to stop order...Incorrect order confirmation...transcription error..."

Review of facility investigation dated and signed by the CE/QA Nurse on March 19, 2014, revealed, "...What causes this occurrence?...Carelessness..." Continued review revealed, "...What do you suggest to prevent similar occurrences?...I would think that if the med nurse has to override a med consistently they would check the order- hopefully before the 22nd dose..."

Resident #452 was admitted to the facility on January 24, 2014, with diagnoses including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 78	F 309		

Intervertebral Disc Disorders, Thoracic Region, Urinary Tract Infection, Osteoarthrosis, Diabetes, and Hypertension.

Medical record review of a Physician's Order dated January 27, 2014, revealed "...Hydrocodone [narcotic pain reliever] 5/325 mg po Q [every] 8 h [hour] scheduled [and] Q 6 [hours] PRN [as needed] pain..."

Medical record review of a prescription dated January 27, 2014, revealed "...Oxycodone/APAP [narcotic pain reliever] 5/325...1 tab [tablet] po Q 6 [hours] PRN pain...1 tab po Q 8 [hours] schedule..."

Medical record review of a Physician's Order dated January 31, 2014, revealed "...Discontinue Hydrocodone order [and] continue Oxycodone order per script..."

Medical record review of the MAR dated January 24, 2014, through January 31, 2014, revealed "...1/27/14 Hydrocodone...325 mg-5 mg 1 tab...oral every 8 hours for pain..." Continued review revealed the resident received the Hydrocodone scheduled every eight hours from January 27, 2014, through January 30, 2014.

Medical record review of the MAR dated January 24, 2014, through January 31, 2014, revealed "...Hydrocodone...325 mg-5 mg 1 tab...oral every 6 hours prn for pain..." Continued review revealed the resident received the medication prn on January 27 and 28, 2014.

Medical record review of the MAR dated January 24, 2014, through January 31, 2014, revealed "...Percocet (Oxycodone) 325 mg-5 mg...oral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 79	F 309		

every 6 hours prn for pain..." Continued review revealed the resident received the Percocet on January 24, 2014, through January 28, 2014, and on January 30, 2014.

Review of the facility investigation dated February 4, 2014, revealed "...Event Date: 1/27/2014...Wrong Medication...MD [Medical Doctor #2] wrote order in chart for Hydrocodone 5/325 mg Q 8 hr and Q 6 hr-prn. [Medical Doctor #2] wrote a prescription for Oxycodone 5/325 mg Q 8 hr and Q 6 hr-prn for the same patient on the same date. Prescription was not signed off and not noted if it had been faxed to pharmacy. Pt. received both medications. Script omission not caught on 24 hour chart check and not by the RN in charge. However, while researching this error, I discovered this MD likes to fax the script to pharmacy and then put the script in the WC basket at the desk. This is not how the process is meant to flow. All scripts are to be placed in the chart for the order to be faxed and secured to the physician order form to be processed and signed off by staff..."

Interview with the CE/QA Nurse on September 25, 2014, at 10:30 a.m., in the conference room, confirmed the resident received both the Oxycodone and Hydrocodone on January 27, 28, and 30th. Continued interview confirmed the nurse should have clarified the order, it was discovered on January 31, 2014, by chart check because the NP wrote an order to discontinue the Hydrocodone on this date.

Interview with the resident's physician on September 29, 2014, by telephone, at 3:50 p.m., confirmed did not intend for the resident to have both Oxycodone and Hydrocodone.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 80	F 309		

Resident #454 was admitted to the facility on February 6, 2014, with diagnoses including Rehabilitation, Osteoporosis, Backache, Difficulty Walking, and Anemia.

Medical record review of a physician's order dated February 27, 2014, revealed a medication order "...Cefdinir [an antibiotic] 300 mg PO q 12 hours x 5 days..."

Medical record review of the Medication Administration Record dated February 6, 2014, through March 6, 2014, revealed the order for the medication was entered to start on February 27, 2014, and entered with a stop date for March 6, 2014 (7 days later) instead of for March 4, 2014, (5 days later). Continued review revealed the resident received 5 extra doses of the antibiotic.

Review of facility investigation signed and dated March 6, 2014, revealed, "...Cause of error...Order not signed off correctly...Daily chart check error...Order entry-transcription error..." Continued review revealed, "...Additional information and patient condition: No stop date entered into computer when order put in..."

Review of facility investigation with date received March 17, 2014, revealed, "...No stop date entered into computer and patient got 5 extra days of medication= [equals] 5 doses...Chart check error...incorrect order confirmation...transcription error..."

Review of facility investigation signed and dated by the CE/QA Nurse on March 17, 2014, revealed, "...What causes this occurrence? Carelessness...What do you suggest to prevent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 81	F 309		

similar occurrences? Be careful..."

Interview with Ward Clerk #6 on September 29, 2014, at 2:24 p.m., in the conference room, confirmed the medication order for the antibiotic was transcribed incorrectly for 7 days instead of 5 days. Continued interview revealed the Ward Clerk had not been made aware of the transcription error prior to the interview.

Interview with RN #1 on September 29, 2014, at 3:50 p.m., by phone, confirmed had completed the 24 hour chart check of the resident's medications. Continued interview confirmed the RN did not identify the transcription error during the 24 hour chart check. Further interview revealed the RN was not made aware by nursing administration of the nurse's failure to identify the error prior to the interview.

Resident #455 was admitted to the facility on February 24, 2014, with admitting diagnoses of Urinary Tract Infection, Pressure Ulcer lower Back, Osteoporosis, and Osteoarthritis.

Medical record review of a physician's order dated March 3, 2014, revealed an order for Prilosec [an antacid] 20 mg qd [daily]. The Physician reordered the Prilosec 20 mg qd on March 8, 2014.

Review of the resident's MAR for March, 2014, revealed Prilosec 20 mg was not administered from March 3 through March 8, 2014.

Medical record review of a facility investigation dated March 13, 2014, revealed the order for Prilosec 20 mg qd was overlooked by LPN #9 and by RN #1 on the twenty-four hour chart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 82	F 309		

check. The cause for the error was listed as failure to read complete order sheet for orders with an intervention to prevent future occurences of "...make sure to check for all dates..." and "...check dates on orders..."

Interview with RN #1 on September 25, 2014 at 3:45 p.m., by telephone, confirmed the order had been missed on the twenty-four hour check.

Interview with LPN #9 on September 25, 2014, at 4:30 p.m., in the conference room, confirmed the order for Prilosec 20 mg every day had been missed.

Interview with the CE/QA Nurse on September 29, 2014, at 3:45 p.m., in the conference room, revealed "... initiated the medication error report..." and confirmed the medication error.

Resident #456 was admitted to the facility on February 25, 2014, with diagnoses including Rehabilitation, Intracranial Hemorrhage following Injury, and Muscle Weakness.

Medical record review of a physician's order dated March 20, 2014, revealed a physician's order "...Change Amitriptyline [antidepressant medication] 10 mg po qhs [at bedtime] x 5 days then d/c..."

Medical record review of the Medication Administration Record dated February 25, 2014, through March 25, 2014, revealed "...3/20/14 Amitriptyline Hydrochloride 10 mg tab...oral every night at bedtime...stop date 3/21/14..." Continued review of the Medication Administration Record revealed the resident received the medication on March 20, 2014, and did not receive another dose

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 83	F 309		

of the medication until March 22, 2014, when the medication error was discovered resulting in the resident missing one dose of the scheduled medication.

Review of facility investigation signed and dated March 22, 2014, revealed, "...Receive orders error: Order put in wrong..." Continued review of facility investigation revealed, "...Nursing Supervisor Comments/Actions to prevent Occurrence in Future: Will re-educate on order take off with stop dates included..."

Review of facility investigation with date received April 1, 2014, revealed, "...chart check error...delay in processing order(s)...error in documentation...incorrect order confirmation...transcription error..."

Review of facility investigation signed and dated by CE/QA Nurse on April 7, 2014, revealed, "...What causes this occurrence? Put in computer wrong 5 day order put in for 1 day only start date 3/20 end 3/21..." Further review of facility investigation revealed the section "...What do you suggest to prevent similar occurrences?..." was blank.

Interview with RN #6 on September 29, 2014, at 3:26 p.m., in the conference room, confirmed RN #6 completed the 24 hour chart check for the resident. Continued interview confirmed the RN did not identify the transcription error during the 24 hour chart check.

Resident #279 was admitted to the facility on April 5, 2014, with diagnoses of Rehabilitation, Aftercare for Healing Traumatic Fracture of Hip, Pneumonia, Urinary Tract Infection, and Diabetes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 84	F 309		

Mellitus.

Medical record review of a physician's order dated April 10, 2014, revealed an order for Rocephin [an antibiotic] 1 Gram IV now and daily x 7 days.

Review of the resident's MAR for April, 2014, revealed the order had not been transcribed to the MAR. Continued review of the resident's MAR revealed the Rocephin had not been given from April 10 through April 13, 2014. Four doses of Rocephin had not been administered per the physician's order.

Review of a facility investigation dated April 17, 2014, revealed the order for the Rocephin 1 gram IV had not been transcribed and the cause was documented as order not processed. A suggestion to prevent similar occurrences was RN must review orders thoroughly for accuracy and 24 hour chart check in place for a double check.

Interview with RN #10 on September 25, 2014, at 11:17 a.m., in the conference room, after observing the physician's order on April 10, 2014, confirmed the medication error had been made. RN #10 had not been made aware of the medication error by the CE/QA Nurse.

Interview with charge RN #4 on September 25, 2014, at 1:35 p.m., by telephone, when asked about the missed medication verification for the dosages of Rocephin "...had no specific memory...when a medication error record was initiated...was usually notified...not aware of this medication error...if...initialed the order and the medication was missed, it was...responsibility and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 85	F 309		

medication transcription policy was not followed..."

Resident #111 was admitted to the facility on July 21, 2014, with diagnoses including Rehabilitation, Traumatic Fracture of the Hip, Osteoporosis, and Difficulty Walking.

Review of the physician orders dated July 21, 2014, revealed "Oxycodone [synthetic opioid narcotic] 5 mg, 1 tab ORALLY, every 4 hours as needed, for 3 days, as needed, pain management." Continued review revealed WC #1 signed off the order at 10:32 p.m., on July 21, 2014, and RN #6 signed off the order at 1:31 a.m., on July 22, 2014. Further review of the physician orders revealed a duplicate Oxycodone order from a prescription detail (paper prescription used for narcotics) signed off by WC #1 at 10:24 p.m., on July 21, 2014, and RN #6 on 1:14 a.m. on July 22, 2014.

Review of the 24 Hour Chart Check dated July 22 and 23, 2014, revealed the signature of RN #6.

Review of the MAR for July 2014, revealed "Oxycodone HCL oral every 4 hours prn for moderate pain." Continued review revealed the Oxycodone was given from July 25 through July 29, 2014, after it had been discontinued. Further review revealed the Oxycodone had been given by four LPN's (#2, #14, #4, and #6) for five additional days and eleven additional doses after the stop date of July 24, 2014.

Review of the facility investigation dated July 29, 2014, revealed "...medication was not discontinued after 3 days as ordered..." and resident #111 continued to receive Oxycodone 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 86	F 309		

mg for five additional days and eleven additional doses. Continued review revealed the report was generated by LPN #15.

Review of the facility investigation dated August 8, 2014, revealed "...order entry error- missed by RN sign off w [with] 24 hour chart check..." Further review revealed the report was signed by RN #8 PCC.

Review of the facility investigation dated August 12, 2014, revealed "...medication not stopped after 3 days as ordered...Parameters...Transcription error, chart check error, incorrect order confirmation..."

Review of the facility investigation of the August medication errors for resident #111, dated August 13, 2014, revealed "...Rushing-there were 9 admissions that day for 1 WC & 1 RN after 11:00..." Continued review revealed the review was conducted by the Clinical Educator/Quality Assurance Nurse.

Interview with the RN #6 on September 29, 2014, at 10:15 a.m., in the conference room, confirmed signed off the admission orders and the 24 hour chart check. Continued interview confirmed "...we look back for 24 hours only, so if it gets missed, that's how it stayed on the MAR..."

Interview with the RN #8 PCC on September 29, 2014, at 4:45 p.m., in the conference room, confirmed "...it was an input error...we didn't bring it up in the QA [Quality Assurance] meetings, we don't review all of the medication occurrences..."

Interview with LPN #14 on September 30, 2014, at 8:20 a.m., by telephone, confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 87	F 309		

administration of the Oxycodone "...how can the resident get the dc (discontinued) med (medication) if it's on the MAR, that's how I gave it..."

Interview with the DON, on October 1, 2014, at 2:20 p.m., in the conference room, confirmed the facility failed to ensure correct medication administration for resident #111.

Resident #398 was admitted to the facility on July 21, 2014, with admitting diagnoses of Rehabilitation Process of Right Total Knee Replacement, Hypertension, Asthma, Difficulty in Walking, and Obstructive Sleep Apnea.

Medical record review of a physician's order dated July 21, 2014, revealed an order for diazepam 5 mg (an antianxiety medication) BID (twice a day), PRN (as needed).

Medical record review of MAR for July 21, 2014, through July 29, 2014, revealed diazepam 5 mg had been transcribed as scheduled to be administered twice per day, at 8:00 a.m., and 10:00 p.m. Further review of the MAR revealed fifteen doses of the medicine had been given.

Review of a facility investigation dated July 29, 2014, revealed the order for diazepam 5 mg as needed twice daily was transcribed into the computer as a routine scheduled order twice daily "... the reason for the occurrence was rushing-9 admissions, 1 w/c [ward clerk] & 1 RN, no preventative measures were identified..."

Interview with pharmacy consultant #1 on September 29, 2014, at 2:35 p.m., in the CE/QA Nurse's office, revealed, "...had no prior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 88	F 309		

knowledge of the medication error..."

Interview with WC #1 on September 29, 2014, at 2:50 p.m., in the DON's office, revealed, "... was aware of the transcription error..." and confirmed making the error.

Interview with RN #4 on September 29, 2014, in the conference room, at 3:40 p.m., confirmed the diazepam 5 mg had been transcribed incorrectly as a scheduled medication, and the RN missed the transcription error on the admission order and the twenty four hour chart check.

Resident #105 was admitted to the facility on July 10, 2014, with diagnoses including Rehabilitation, Acute Renal Failure, Hypertension, Hypopotassemia, and Diabetes Mellitus.

Medical record review of a physician's order dated July 10, 2014, revealed Potassium Chloride (electrolyte replacement for low blood levels of potassium) Extended Release Tablet, 10 milliequivalent (meq) every day. Further review revealed Ward Clerk #3 signed off the order on July 10, 2014, at 3:27 p.m., and Registered Nurse (RN) Charge Nurse #2 signed off the order on July 10, 2014, at 4:29 p.m.

Medical record review of the Physician's Orders, dated July 23, 2014, at 6:30 p.m., revealed "KCL [potassium chloride] 20 meq po (every morning) (start in am) x (times) 3 days (edema)". Further review revealed the order was signed off by RN #5 July 23, 2014, at 7:35 p.m.

Medical record review of the MAR revealed the order for "...Potassium Chloride 20 meq oral once a day..." dated for three days, July 24, 25, and 26,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 89	F 309		

2014. Further review revealed the Potassium Chloride 10 meq ordered on July 10, 2014, was not placed on hold and remained on the MAR.

Medical record review of the MAR revealed on July 24, 2014, LPN #10 administered the 20 meq Potassium Chloride tablet and the 10 meq Potassium Chloride tablet for a total of 30 meq of Potassium Chloride.

Medical record review of the Physician's Orders dated July 25, 2014, at 8:23 a.m., revealed "...kcl on hold until 7/27 due to increase in medications..."

Review of the facility investigation, dated August 14, 2014, revealed "...Pt already on KCL 10 meq daily, but new order for 20 meq x 3 days received. 10 meq not placed on hold so the pt received 30 meq on the first day of the three day order. WC did not notice the 10 meq order needed to be placed on hold..."

Interview with RN Charge Nurse #7 on September 29, 2014, at 5:45 p.m., by telephone, confirmed, "...the old order wasn't placed on hold..."

Interview with the DON on September 29, 2014, at 2:25 p.m., in the conference room, confirmed when a new order is written for the same medication, "...the old order has to be discontinued by the ward clerk, the new order does not supersede the old order..."

Interview with the Clinical Educator/Quality Assurance Nurse on September 30, 2014, at 10:00 a.m., in the conference room, confirmed "...the ward clerk didn't notice the 10 meq (of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 90	F 309		

potassium chloride) needed to be placed on hold...some people can't multitask..."

Resident #197 was admitted to the facility on July 24, 2014 with diagnoses of Trans Cerebral Ischemia, Esophageal Reflux, Hypothyroidism, Hypertension, and Depressive disorder.

Review of the resident's admission orders dated July 24, 2014, revealed physician orders for Seroquel 200 mg (an antipsychotic medication), q hs (hour of sleep), Sertraline 25 mg (an antidepressant medication) qhs, Pravastatin 40 mg (an anticholesterol medication) q hs, and Resperidone 0.5 mg (an antipsychotic medication) q hs.

Medical record review of the MAR on the admission date of July 24, 2014, revealed the Seroquel 200 mg, Sertraline 25 mg, Pravastatin 40 mg, and Risperidone 0.5 mg were not administered on July 24, 2014.

Medical record review of the facility investigation dated July 25, 2014, revealed the resident was not given Seroquel 200 mg, Sertraline 25 mg, Pravastatin 40 mg, and Risperidone 0.5 mg, due to a transcription error, due to the ward clerk transcribed the medication orders to another resident's MAR, caused by the name on computer profile not checked. There were no recommendations made for future prevention of the error.

Interview with WC #1 in the DON's office, on September 29, 2014, at 2:50 p.m., confirmed transcribed the medication incorrectly.

Interview with RN #5 on September 23, 2014, at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 91	F 309		

10:45 a.m., by telephone, confirmed the RN failed to notice or take action for the medication omission on the initial chart check, and on the twenty-four hour check.

Interview with the Medical Director, on September 29, 2014, at 10:10 a.m., in the conference room confirmed "...was aware of the medication error..."

Interview with pharmacy consultant #1 on September 25, 2014, at 9:45 a.m., by telephone, revealed was aware of the medication error on July 25, 2014, and had discussed the incident with the CE/QA Nurse.

Interview with CE/QA Nurse on September 29, 2014, at 3:45 p.m., in the conference room, revealed, "...had initiated the medication error report and was aware of the medication error..."

Resident #23 was admitted to the facility on July 29, 2014, with diagnoses of Diastolic Heart Failure, Pressure Ulcer, Esophageal Reflux, and Muscle Weakness.

Medical record review of the resident's admission orders revealed an order for Restoril (a sleeping pill) 15 mg qhs (every night) PRN (as needed).

Review of the resident's Medication Record revealed the medication was on the MAR as a routine medication and a PRN medication. Continued review revealed the medication had been administered to the resident as a routine medication eight times from July 29, through August 5, 2014.

Review of a facility investigation dated August 7,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 92	F 309		

2014, revealed the order for Restoril was put into the computer as QHS (every hour of sleep) routine and an additional order was put in for Restoril 15 mg QHS PRN. The reason for the occurrence was the order was not entered correctly upon admission, and and intervention to prevent similar occurrences was orders need to be thoroughly correct when signing off.

Interview with RN #8 on September 29, 2014, at 8:40 a.m., in the CE/QA Nurse's office, confirmed the Restoril had been transcribed incorrectly as a PRN and scheduled medication, resulting in medication errors for resident #23.

Interview with RN #5 on September 29, 2014 at 4:25 p.m., by telephone, revealed, "...did not remember specific medication error...if initialed the admission order and the twenty-four hour check, and the error was not caught, the RN was responsible for not identifying the error..."

Resident #411 was admitted to the facility on August 2, 2014, with admitting diagnoses of Post Lumbar Laminectomy, Hypertension, Muscle Weakness, and Difficulty in Walking.

Medical record review of a physician's order dated August 5, 2014, revealed an order for a one-time dose of a Dulcolax Suppository (a stool softener) and a one time dose for a bottle of Magnesium Citrate (a bowel cleansing agent) in the morning of August 6, 2014.

Review of the resident's MAR for August, 2014, revealed the order for Dulcolax and Magnesium Citrate had been transcribed as a scheduled dose to be given every day. Continued review revealed the Dulcolax suppository and the Magnesium

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 93	F 309		

Citrate orders had been initialed as held, due to resident refusal, on the morning of August 6, had been initialed as given on August 9, 10, and 25, 2014, for a total of three doses of each medication.

Review of a facility investigation dated September 4, 2014, revealed, "... med order was Dulcolax Supp. [suppository] X 1 in am, order was processed as Dulcolax Supp. PR (per rectum) daily @ [at] 9:00, this was on emar (electronic medication administration record) x 23 days but pt. refused all but three doses. [RN #11] notified me of error on 8/28/14...[there was total of 2 extra doses given], cause of occurrence: order not processed correctly; Prevent similar occurrences: need to read order and 24 hour chart checks already in place to help avoid these errors..."

Interview with RN #4 on September 29, 2014, at 9:35 a.m., by telephone, confirmed the failure to accurately transcribe the order was missed on the twenty-four hour check on August 5, 2014, resulting in medication errors.

Interview with RN #6 on September 29, 2014, at 10:10 a.m., in the conference room, confirmed the inaccurate transcription of the order for the one-time dose for a Dulcolax suppository and a one-time dose for a bottle of magnesium citrate were missed by the charge RN, resulting in medication errors.

Interview with pharmacy consultant #1 on September 29, 2014, at 2:35 p.m., in the CE/Q Nurse's office revealed, "...had no prior knowledge of the medication error..."

Interview with WC #1, on September 29, 2014, at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 94	F 309		

2:50 p.m., in the DON's office, confirmed the WC made the error of inaccurate transcription of the physician orders.

Resident #238 was admitted to the facility on August 14, 2014, with diagnoses including Aortocoronary Bypass, Dysphagia, Muscle Weakness, Difficulty in Walking, Diabetes, Hypertension, and Hyperlipidemia.

Review of the Admission MDS dated August 27, 2014, revealed the resident had a BIMS of 13 (resident cognitively intact).

Medical record review of the Physician Orders dated August 2014 revealed an order "...August 14, 2014, Furosemide [diuretic medication] 20 mg tab oral daily @ 6 am for edema..."

Medical record review of the Physician's Orders dated August 19, 2014, revealed order "...Lasix [Furosemide] 40 mg po now [Immediately] and give another 20 mg at 6 pm...Increase Lasix in am to 40 mg daily..."

Medical record review of the Physician telephone orders dated August 20, 2014, revealed, "...D/C Lasix..."

Medical record review of the Medication Administration Record dated August 2014, revealed the resident did not receive the now dose of medication as ordered by NP #2 on August 19, 2014. Continue review revealed the medication was scheduled to be given at 2:45 p.m., was not given per Physician's order.

Medical record review of the Medication Administration Record dated August 2014,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 95	F 309		

revealed the resident received Furosemide 40 mg daily on August 21, and August 22, 2014, two days after the medication had been discontinued.

Review of the facility investigation prepared August 22, 2014, revealed "...Drug name Lasix...Medication Order D/C Lasix...Wrong Dosage...Cause of Error Order Not Signed Off Correctly...Lasix was discontinued...Was patient aware of medication error? No... Drug had been entered in under generic name as well so not noticed when signing order...Admission orders had generic name and NP wrote for Brand name to be discontinued. WC and RN did not catch generic name..."

Review of the facility investigation with date received August 29, 2014 revealed "...Chart Check Error...Did Not Read Drug Label...Incorrect Order Confirmation...Transcription Error...Comments: Admission orders listed meds in generic forms. NP stopped it but called by brand name...RN did not catch the generic form of the drug when signing off orders and the 24 hour chart check did not catch it neither..."

Medical record review of the 24 Hour Chart Check form revised March 2014, revealed 24 hour chart check was signed as completed on August 21, 2014, at 6:13 a.m. Continued review revealed the 24 hour chart check failed to identify the resident had an order to discontinue Lasix on August 20, 2014.

Interview with the Clinical Educator/Quality Assurance Nurse on September 25, 2014 at 1:41 p.m., in the conference room revealed "...The resident admission orders written were written on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 96	F 309		

August 14, 2014. At that time the resident was on Furosemide...[NP #2] came in on August 19, 2014 and wrote an order for Lasix 40 mg now. The [NP] also increased Lasix to 40 mg daily... [LPN #3] gave the doses of Furosemide to the resident...[Ward Clerk #5] did not know that Lasix and Furosemide are the same medication so the Furosemide remained on the Medication Record..." Further interview with the CE/QA Nurse revealed "...[RN#11] Charge Nurse was supposed to compare the written orders with the computer...The nurse did not do that..."

- Continued interview revealed RN #6 during review of the MAR discovered the medication error on August 22, 2014, at 10:44 p.m., two days later.

Interview with LPN #3 on September 25, 2014 at 4:33 p.m., by telephone, revealed LPN #3 administered Furosemide 40 mg tablet to the resident on August 21, and August 22, 2014. Continued interview revealed LPN #3 was not aware of the medication error with Furosemide, until the interview with the surveyor.

Interview with RN #6 on September 29, 2014, at 9:21 a.m., in the conference room revealed "...No one realized that Lasix and Furosemide was the same drug so the resident continued to receive the Furosemide 40 mg for two days after medication was discontinued by the Physician on August 20, 2014..."

Interview with NP #1 on September 29, 2014 at 11:00 a.m., in the conference room revealed "...I write orders...I do not look at the EMARS [electronic medication administration records] routinely..." Continued interview revealed "...I was unaware of all the medication errors involved..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 97	F 309		

Interview with Pharmacy Consultant #1 on September 29, 2014 at 11:47 a.m., in the conference room revealed "...The pharmacist should have realized the duplicate orders for Furosemide when they were submitted..." Continued interview revealed the pharmacy failed to reconcile the MAR and physician orders.

Interview with RN #11 Charge Nurse on September 29, 2014, at 2:06 p.m., at the main nursing station revealed "...No one informed me of the medication error made August 19, 2014, where I signed off the order for Lasix 40 mg now..."

Interview with Ward Clerk #5 on September 29, 2014 at 2:45 p.m., by telephone, revealed unaware of medication error regarding now dose of Furosemide. Continued interview revealed "...No one told me about the error...I take the orders off then put the order in the computer then place the chart in the nurse's box and the nurses recheck it..."

Interview with CE/QA Nurse on September 29, 2014, at 4:47p.m., in the conference room, revealed three medication errors occurred: the Lasix 40 mg now was not given August 19, 2014; Furosemide 40 mg was given August 21, 2014; and Furosemide 40 mg was given August 22, 2014.

Interview with RN #2 Charge Nurse on September 30, 2014, at 8:19 a.m., by telephone revealed "... the Furosemide and Lasix was both listed on the MAR...I looked at the Lasix order on August 20, 2014 to discontinue Lasix...I didn't discontinue Furosemide..." Continued interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 98	F 309		

revealed "...I just looked at the one medication [Lasix]...I didn't know it under two different names..."

Interview with LPN #11 on September 30, 2014, at 9:16 a.m., in the conference room, confirmed LPN #11 did not give the Lasix 40 mg now dose.

Interview with the Administrator on September 30, 2014, at 10:12 a.m., in the conference room, revealed the Administrator was aware of medication errors. Continued interview revealed the Administrator stated the medication errors were more of an individual problem, and "...have been handled on an individual basis..." Further interview revealed the Administrator stated there was a problem in the three step process of transcription and verification of physician's orders (#1. The ward clerk transcribing physician's orders correctly from the paper orders into the electronic MAR, #2. The RN checking to verify the orders were correct, and #3. The Night Shift RN Checklist double-checking for any transcription errors). Further interview revealed, "...I don't think we have come down to a clear answer...I don't know the root cause of the problem..." The Administrator stated individual nurses who made the medication errors not being informed/re-educated was "...a problem..." Further interview confirmed the Administrator had not identified a trend with the repeated occurrence of medication errors.

Interview with the DON on September 30, 2014, at 11:10 a.m., in the conference room, revealed "...We have a problem with the three step process regarding taking off orders...it is a combination of things...I don't think we have come down to a clear answer...I do not know the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 99 root cause of the problem..." Continued interview confirmed the facility failed to verify the accuracy in the transcription of the physician's orders to the electronic MARs. Reviews of facility policy, medical record reviews, reviews of facility investigations, and interviews, revealed the facility had a repeated pattern of medication errors which were the result of the inaccurate transcription and verification of physician's orders to the electronic MAR. Reviews revealed the facility was aware of the medication errors but failed to identify the root-cause of the errors. Interviews with the facility's managment which included the Administrator, Medical Director, DON, and CE/QA Nurse confirmed all were aware of medication errors which had occurred as the result of inaccurate transcription and verification of physician's orders to the electronic MARs. Interviews confirmed the facility continued to address the errors on an individual basis on investigation reports (did not notify the nurse who made the error or re-educate); and failed to identify and develop a plan of action to address the systemic failure of transcription and verification of physician's orders. The Immediate Jeopardy was effective from February 12 through October 1, 2014, and was removed onsite on October 2, 2014. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the surveyors through review of documents, staff interviews, and observations conducted onsite on October 2, 2014. The surveyors verified the allegation of compliance by:	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 100	F 309		

1. Review of the facility's in-service records to ensure nursing staff were educated regarding changes for medication administration which included the implementation of paper Medication Administration Records (MARs). Review included the facility's plan of action to ensure all nurses were educated on the new system before being allowed to work a shift (coordinated by the Director of Nursing), and the facility's plan for education for nurses who were not scheduled to work or who were on vacation or Family Medical Leave.
2. Verification of the new medication administration system by the facility which included discontinuation of the Electronic Medication Administration Record (EMAR) and implementation of paper Medication Administration Records. Verification included review reconciling new physician's orders and the correct reconciliation to the new paper MARs.
3. Verification through interview with the Director of Nursing and Medical Director, and review of facility documentation all current resident's medication orders were accurately transcribed to paper MARs.
4. Verification through interview with Director of Nursing and review of the Medication Occurrence Report modified to require the date and time of notification of resident and/or family of medication errors.
5. Verification through interview with the Administrator, and review of facility documentation the facility's identification of eight transcription errors during the facility's audit of all current resident's medication orders. Review of facility documentation verified residents or resident's family, and physician were notified of the errors. Verification through interview with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 101 Medical Director of immediate intervention to assess resident's status after identification of the error, and provide clarification orders where needed. 6. Review of a random sample of active resident charts to verify the accurate transcription of new physician's orders to the paper MARs. Review of random sample of active resident charts for the completeness and accuracy of 24 hour chart checks. 7. Verification through observation in both nursing stations new orders were being transcribed by Registered Nurses only. 8. Verification through observation of 3 Licensed Practical Nurses (two on the ground floor and one on main floor) of medication administration by Licensed Practical Nurses with the addition of Registered Nurses assisting to ensure the accuracy of administered medications. 9. Verification through interviews with nine Registered Nurses, seven Licensed Practical Nurses, and three Ward Clerks/Certified Nursing Assistants to determine the comprehension gained through in-services conducted by the Director of Nursing regarding the changes and implementation of the facility's new transcription and verification procedures. 10. Verification through interview with the Administrator, Medical Director, Chief Nursing Officer, Risk Management Team, Director of Nursing, and Director of the Pharmacy Vendor of their participation in risk management meeting to address the system changes with medication administration, and involvement of all parties in ongoing quality assurance. 11. Verification through observation and interview with ward clerks and registered nurses the facility discontinued the process of entering physician orders electronically by the ward clerks.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 309	Continued From page 102 12. Verification through observation faxed medication orders were reconciled in real time. 13. Verification by interview with the Director of Pharmacy Vendor the pharmacy consultant will reconcile new medication orders weekly. Non-compliance continues at an "F" level for monitoring the effectiveness of corrective actions and evaluation of monitoring by the Quality Assurance Committee. The facility is required to submit a plan of correction.	F 309		
F 325 SS=G	c/o #34603 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on review of facility policies, medical record review, and interview, the facility failed to prevent a significant weight loss for one resident (#388) of four residents reviewed for nutritional status of forty-one residents reviewed. The facility's failure resulted in harm for resident #388.	F 325	F325 MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; After further review of resident #388's medical record by the Transitional Care Center (TCC) (facility) Medical Director, it was found that the Nurse Practitioner had been notified of the resident's weight loss on September 23, 2014 by the Registered Dietician (RD) (see exhibit 1). The Nurse Practitioner and RD continued to closely monitor the resident and ordered lab tests as was deemed appropriate and necessary in their professional opinions. The RD was in communication with both the providers and family members of the resident. The weight loss was identified and communicated to all necessary parties. Several interventions, including dietary supplements, increased weight monitoring, and a high calorie diet were implemented. Weight loss was, in part, explained by acute illnesses requiring provider interventions throughout the entire course of stay.	10/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 325	Continued From page 103 The findings included: Resident #388 was admitted to the facility on August 8, 2014, with diagnoses including Rehabilitation, Cellulitis of the Leg, Pressure Ulcer of the Buttock, Congestive Heart Failure, and Diabetes Mellitus. Review of the policy, Pressure Ulcer Management, revised July 2013, revealed "...monitor nutritional status, including food and fluid intake. Assess Pre-albumin, Transferrin, and Albumin levels to determine protein status..." Review of the Supervision of Resident Nutrition, revised October 2009, revealed "...food and fluid intake must be observed...recorded and reported..." Medical record review of the facility's Standing Admission Orders, dated August 15, 2014, revealed "...RD/CDM (Registered Dietician/Certified Dietary Manager) will evaluate and make adjustments for adequate caloric and/or protein intake...nutritional supplements will be provided to patients requiring increased intake..." Medical record review of the resident's Nutritional History, dated August 18, 2014, revealed an admission weight of 99.4 pounds, UBW (Usual Body Weight) of 96 pounds, and a BMI (Body Mass Index) of 18 (underweight less than 18.5). Continued review of the nutritional history dated August 18, 2014 revealed a diet order of "CCHO (Consistent Carbohydrate Diet) c (with) glucerna (nutritional supplement) c meals/Regular. glucerna TID (three times a day)."	F 325	Resident #388 was discharged on October 3, 2014 with no significant complications of weight loss. She was discharged to her home in Assisted Living with Home Health to follow. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents in the TCC (facility) were considered to have the potential to be affected. Following notification of deficient practice, the Medical Director, RD, Certified Dietary Manager (CDM), and Patient Care Coordinators (PCCs) worked together informally to evaluate the current weight and intake of all residents. This occurred from October 16, 2014 to October 27, 2014. In addition, beginning on October 7, 2014, Registered Nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), and Ward Clerks (WCs) were educated in huddles (see exhibit 10) that daily weights are to be done by nightshift. When reviewing the careplans, RNs are to be sure the CNAs are aware of which residents require weights. On Monday, Wednesday, and Friday there is a day shift CNA coming in at 6:30am on each floor to obtain residents' weights. After the RN has reviewed the weights, he or she is to put the copy in the PCC's box to review. Huddles are small and informal meetings involving RNs, LPNs, CNAs, and WCs present that shift. They are held at the beginning of each shift daily and conducted by the RN charge nurse. They provide a brief discussion of any announcements, reminders, or updates and content is determined by the Nursing Leadership Meeting (see exhibit 7). Content from huddles is also placed in the huddle book so that staff not present may review it as well.	

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F 325	Continued From page 104 Further review of the nutritional history dated August 18, 2014, revealed, "...alert, confused...r (right) heel SDTI (suspected deep tissue injury), r buttock decubitus (pressure ulcer)...consumes 75% (percent) (of meal)... suggest daily MVI (multivitamin), vit C (Vitamin C) and Zinc to promote wound healing..." Medical record review of the 5 day Minimum Data Set (MDS) dated August 22, 2014, revealed a Brief Interview Mental Status (BIMS) of 9 (indicating moderate cognitive impairment), supervision for eating, set-up only, and a weight of 99 pounds. Medical record review of the dietary notes dated August 28, 2014, revealed "...pt (patient) request/family change glucerna to 2 pm..." Medical record review of the Plan of Care, dated August 28, 2014, "...Needs therapeutic diet related to low BMI...interventions...Regular diet with Glucerna once daily, monitor meal consumption offering substitutes if resident consumes less than 50% of meals..." Medical record review of the Weights Detail Report revealed a weight of 95 pounds (4.1% loss) dated on September 7, 2014. Continued review revealed a weight of 91 pounds (8.1% loss) on September 22, 2014. Medical record review of the Interdisciplinary Progress Notes of August 25 to September 23, 2014, revealed no documentation of weight loss. Medical record review of the facility's Meal & (and) Fluid Detail Report from August 24 to September 21, 2014 revealed the Glucerna 2:00	F 325	As a consequence of this intensive review and evaluation, an additional 10 residents were found to be at high risk for weight loss and placed on a "high risk for weight loss" list, created prior to October 27, 2014. Risk stratification was determined by meeting a minimum of 1 of 3 criteria: Body Mass Index (BMI) less than 19, recorded weight loss, or presence of stage 2 or greater wounds. The following residents were identified as being at high risk: MR# 643209 significant weight loss MR# 426528 significant weight loss MR# 409435 wounds MR# 770881 weight loss MR# 729048 wounds MR# 416632 tube feeding with low BMI MR# 484730 low BMI MR# 512246 weight loss* MR# 1021778 weight loss MR# 436484 weight loss* MR# 575973 wounds MR# 415771 weight loss* *weight loss suspected to be related to inaccurate admission weight reported The first official meeting of the weight management team (see question 4 regarding monitoring of corrective actions) was October 27, 2014. During that meeting, an additional 6 residents were identified to be at risk and added to the high risk for weight loss list. Ongoing review by the RD and PCCs continues to identify additional at risk residents.	

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F 325	Continued From page 105 p.m. documented as consumed on September 5 and 6, 2014. Continued review revealed the resident received Glucerna for two out of twenty-five days. Medical record review of the 30 day MDS, dated September 11, 2014, revealed a BIMS of 10 (10 and above is cognitively intact), supervision for eating, set- up only, and a weight of 95 pounds. Medical record review revealed a CBC (complete blood count), BMP (basic metabolic profile), a Sed (sedimentation) rate (measures inflammatory activity), drawn on September 12, 2014, for "ble (bilateral lower extremity) inflammation, ckd (cyclin-dependant kinase), anemia". Further review revealed the BUN (blood urea nitrogen), a test to measure urea nitrogen that forms when protein breaks down, with a level of 32 mg/dl (milligrams/deciliters), (normal range of BUN of 6 to 20 mg/dl) and the Creatinine (measurement of muscle wasting) level on September 12, 2014, revealed 1.28 mg/dl, (normal level of 0.6 to 1.2 mg/dl). Continued review revealed no Pre-Albumin (blood test for protein deficiency), Albumin (measures protein), or Transferrin (iron metabolism) levels were ordered per facility policy. Medical record review of the laboratory blood work, drawn on September 23, 2014, revealed orders for a CBC and BMP. Further review revealed the BUN of 35 mg/dl and a Creatinine of 3.12 mg/dl. Continued review revealed no Albumin, Pre-Albumin, or Transferrin levels were ordered per policy. Interview with the Certified Nursing Assistants (CNA's) #1, #5, and #6, on September 23, 2014,	F 325	For all residents identified as high risk, recommendations for intervention were made and implemented to prevent further weight loss and decrease risk. This included but was not limited to conversion to a liberal diet, addition of supplement, more aggressive weight monitoring, and laboratory evaluation. Each resident received the applicable interventions as determined by the Medical Director and RD. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; The Medical Director worked directly with the RD, PCC, and CDM in collecting and reviewing all existing policies and procedures governing weight monitoring and nutritional management. They met face to face to evaluate for deficiencies in these policies and procedures. This work culminated in the formation of the Weight Management team and creation of the "Identifying and Maintaining an Adequate Weight for All Patients Considered High Risk for Weight Loss" policy (see exhibit 23) on October 21, 2014. The purpose of the policy is to identify, monitor, and maintain an adequate weight for all residents considered to be at high risk for weight loss. The policy was created, reviewed, and discussed October 22, 2014 with approval by the Interim DON, CNO, and Medical Director. Educational in-service (see exhibit 4) on this policy was conducted by the Interim DON, Interim CE, and PCCs from October 22, 2014 through October 25, 2014, and included all RNs, CNAs, LPNs, and WCs. Copies of the policy were distributed and reviewed with the staff by the instructor during these educational sessions and staff questions were answered. Two staff members were on vacation during this in-service and completed their education to this policy by October 27, 2014 (see exhibit 5). This policy was in effect as of October 25, 2014. New or contract staff will receive education to this policy (see exhibit 23) as part of their new employee orientation packet. This educational material will be updated as policy changes occur by the CE. The CE will also be responsible for educating current RNs, LPNs, CNAs, and WCs of policy changes when they occur. Continued on Page 106(a)	

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F 325	Continued From page 106	F 325	All RDs employed by the hospital who may be assigned to work at TCC (facility) from the parent hospital were educated to the policy "Identifying and Maintaining an Adequate Weight for All Patients Considered High Risk for Weight Loss" (see exhibit 23). The processes for documentation of consumption of dietary supplements and for the RD's recommendation(s) being reviewed and implemented have been revised as outlined in the new policy referenced above. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. The TCC (facility) formed a weight review team on October 21, 2014 to include the PCCs, RD, and CDM, as well as the Medical Director at her discretion or as requested. This group met informally prior to this date beginning October 6, 2014 and the Medical Director led those meetings and sought input on a more comprehensive weight management process. These recommendations were incorporated into the policy "Identifying and Maintaining an Adequate Weight for All Patients Considered High Risk for Weight Loss" (see exhibit 23). This team will meet weekly on Mondays beginning the week of October 27, 2014 to review the weights obtained on all current residents and identify any/all residents with significant weight loss (5% of usual body weight in 6 months), evaluate the intake, including nutritional supplements, of all residents as documented in the medical record for intake less than 50% (including supplements). These criteria are used to identify residents at risk for weight loss, resulting in these residents being added to the "High Risk for Weight Loss" list.	

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F 325	Continued From page 106 (a)	F 325	This list is representative of residents identified as being at high risk of weight loss based upon the following criteria if present at time of admission: BMI less than 19.0, presence of stage 2 or greater wounds, or documented history of Adult Failure to Thrive or Malnutrition. Recommendations will be made by the RD to the physician based on review of the medical record, care plan, and intake records to help ensure residents do not lose weight unexpectedly. A member of the weight team will perform a weekly random audit of the documentation of the percentage of supplements consumed for 20% of residents receiving a supplement for an initial 4 week period (see exhibit 24). Then 10% of residents receiving a supplement for an additional 4 week period will be audited. The Quality Management Plan for TCC Compliance Auditing Tool (see exhibit 21) will be used to determine the volume and frequency of ongoing audits to ensure compliance with the administration and documentation of ordered dietary supplements. Results of the audit will also be reported to the QA committee. Recommendations will be made to the physician if indicated, based on review of the medical record, care plan, and intake records to help ensure residents do not lose weight unexpectedly.	

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F 325	Continued From page 106 at 4:15 p.m., in the dining room, confirmed the CNA's were not instructed to document the 2:00 p.m. snacks. Interview with the Registered Nurse (RN) #2 Charge Nurse, on September 23, 2014, at 4:00 p.m., in the main nursing station, confirmed no knowledge of the resident #388's weight loss. Interview with the Registered Dietician on September 23, 2014, at 4:30 p.m., in the dining room, confirmed the Pre-Albumin, Albumin, and Transferrin labs were not ordered, nutritional supplement was not documented, not aware of the weight loss, and had no further dietary consults with resident #388. Further interview confirmed "...I have been on vacation...the dietary manager doesn't take over for me..." Interview with Director of Nursing (DON) on September 24, 2014, at 7:45 a.m., in the main level nursing station, confirmed the facility failed to obtain labs, document nutritional supplements, and notify dietary or the physician of the weight loss. Continued interview confirmed "...RN's responsibility to notify the RD..." Further interview confirmed "...it doesn't look like the policy was followed..."	F 325	Continued From Page 106(b)	
F 333 SS=L	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and procedure,	F 333	F333 RESIDENTS FREE OF SIGNIFICANT MED ERRORS What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #262 was discharged from the Transitional Care Center (TCC) (facility) on July 25, 2014 to Blount Memorial Hospital, and suffered no permanent or prolonged condition from the noted medication error.	10/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 333	Continued From page 107 medical record review, facility investigation review, and interview, the facility failed to prevent significant medication errors for four residents (#262, #457, #188, #453) of twenty-four residents reviewed for medication errors. The facility's failure to ensure physician's orders were transcribed accurately, failure to ensure the Registered Nurse verified orders for accurate transcription and failure to identify inaccurate medication transcription on 24 hour chart checks resulted in a system failure that placed all residents receiving medication in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death). The Administrator, Medical Director, Chief Medical Officer In House Legal Counsel, Chief Nursing Officer, and Director of Nursing were informed of the Immediate Jeopardy on September 30, 2014, at 4:00 p.m., in the conference room. The Immediate Jeopardy was effective February 12, 2014 through October 1, 2014. An extended survey was conducted on September 30, 2014, through October 2, 2014. F333-L is substandard Quality of Care. An acceptable Allegation of Compliance was received on October 2, 2014, and actions which removed the Immediate Jeopardy were verified on-site on October 2, 2014. Noncompliance continues at the severity of "F". The findings included:	F 333	She discharged from the hospital to a second skilled nursing facility from which she was later discharged to home in good condition. Resident #457 was discharged from the TCC (facility) on March 31, 2014 to home, and suffered no permanent or prolonged condition from the noted medication error. Resident #453 was discharged from the TCC (facility) on March 24, 2014 to home, and suffered no permanent or prolonged condition from the noted medication error. It was determined for resident #188, after additional review of the medical record, the medication dispensing system reports, and pharmacy records, that the resident did not receive Coumadin as documented by the nurse. The nurse entry was inaccurate. This employee no longer works at TCC (facility). In complete review of chart, there was NO order for Coumadin 2 mg to be given to resident. However, an electronic request was sent to pharmacy for Coumadin 2 mg. Pharmacy rejected the order due to admission order clarification for "hold Coumadin". They notified TCC (facility) of rejection of order. The pharmacy (which generates Coumadin orders per protocol) did not generate a Coumadin order for this resident. There was no Coumadin withdrawn from medication dispensing system profile assigned to this resident. Resident #188 was discharged home to Assisted Living with Hospice on April 11, 2014. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents in TCC (facility) were considered to have the potential to be affected. The Electronic Medication Administration Record (E-MAR), Electronic Treatment Administration Record (E-TAR), and Electronic Physician Order Entry (E-POE) system was abandoned immediately on September 30, 2014, returning to a hand-written, paper-based MAR, TAR, and physician order system, effective October 1, 2014.	

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F 333	Continued From page 108 Review of the facility policy Medication Administration: General Guidelines, undated, revealed "...Procedures: 2) Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnoses or condition, the physician is contacted for clarification prior to the administration of the medication. This interaction with the physician is documented in the nursing notes and elsewhere in the medical record as appropriate..." Review of the facility policy Charge Nurse, dated June, 2012, revealed "...C) 2: Reviewing medication cards for completeness of information, accuracy in the transcription of physician orders, and adherence to stop order policies..." Review of the facility procedure Night Shift RN (Registered Nurse) Checklist, undated, revealed "...3). Check charts after midnight (24 hr [hour] chart checks). If any new medications ordered, verify they were on the MAR [Medication Administration Record]..." Resident #262 was admitted to the facility on July 23, 2014, with diagnoses of Pneumonia, Acute Renal Failure, Rehabilitation, Atrial Flutter, and Muscle Weakness. Medical record review of a Medication Record (MAR - record for documenting medication administration) for July 2014, revealed on July 24, 2014, at 9:00 p.m., the resident was given Seroquel 200 mg (milligrams) (an antipsychotic medication), Sertraline 25 mg (an antidepressant	F 333	On September 30, 2014 through October 1, 2014, charts and MARs of 100% of the current residents (68) were reviewed during our conversion from E-MAR to paper MAR. In the process, the records were analyzed for any medication errors by the Medical Director who was on site through the entire conversion process. Our initial review identified 7 residents (8 errors) who we thought were affected. However, on further review, one resident (MR# 425745) had previously been notified of the error and another (one of two on MR# 448221) was found not to be an error. The following residents were affected: Resident MR# 475365: Omission of medication on September 14, 2014. Resident MR# 483234: Transcription error on September 18, 2014. Resident MR# 689434: Transcription error on September 25, 2014. Resident MR# 791005: Transcription error on September 23, 2014. Resident: MR# 524029: Transcription error on September 4, 2014. Resident MR# 448221: Transcription error on September 15, 2014. On September 30, 2014 additional Registered Nurses (RNs), employed by Parent Hospital (Blount Memorial) were assigned to the TCC (facility) to complete the following tasks: • Transcribe all physician orders for every current resident to a hand-written MAR and/or TAR on September 30, 2014 for immediate use. • Verification by 2 RNs the accuracy of all physician orders for every current resident to a hand-written MAR and/or TAR after transcription completed on October 1, 2014.	

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BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 333	Continued From page 109 medication), Pravastatin 40 mg (an anti-cholesterol medication), and Risperidone 0.5 mg (an antipsychotic medication). Medical record review of Physician's orders from July 23, through July 25, 2014, revealed there were no orders for Seroquel, Sertraline, Pravastatin, or Risperidone. Medical record review of a nurse's note dated July 25, 2014, revealed "...05:30 unit secretary found med [medication] error as...was putting in other orders on another pt [patient]. Pt. had 3 meds that were not her orders. VS [vital signs] B/P [blood pressure, normal blood pressure is 120/80]...88/53...Pt very sleepy hard to arouse... [Physician] notified, orders noted..." Medical record review of a nurse's note date July 25, 2014, at 9:45 a.m., revealed the nurse started and intravenous access to administer fluids of normal saline at 60 ml/hr (milliliters per hour), as ordered by the physician, to treat hypotension (low blood pressure). Medical record review of a Physician's progress note dated July 25, 2014, at 1:50 p.m., by NP #1, revealed "...Called to room by [RN] to discuss with [family member] some follow up concerns. [Family member] requests discussion out of room...voices concern Re: [regarding] jerking movements and effects of Seroquel & [and] Risperdal on these movements...In room patient awake - [family] stating not like [normal]. Counseled them on expected side effects Seroquel & Risperdal, todays lab results to include tx [treatment] for elevated potassium and use of IVF [intravenous fluids] for management/correction of hypotension.	F 333	• Provide every 12 hour chart checks to include review of all MAR's, TAR's, and new physician orders effective October 1, 2014. This process is ongoing. • Administer all medications under the purview of two licensed nurses (RN or Licensed Practical Nurse (LPN)) effective October 1, 2014. This process is ongoing. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; Initial education on the transcription and verification process (see exhibit 16) was completed by the Chief Nursing Officer (CNO) on September 30, 2014 during a face to face educational session with all RNs and LPNs present that shift. For the subsequent shifts on September 30, 2014 and October 1, 2014, the Director of Nursing (DON) reviewed the Allegation of Compliance and the process for transcribing and verifying MARs and TARs, chart check process, and new medication occurrence report, with each shift's RNs and LPNs (see exhibit 16). From October 1, 2014 through October 16, 2014 The TCC Medical Director, CNO, Interim DON, Interim CE, and Pharmacy Director developed a process for utilizing a printed MAR established by the pharmacy. This process is outlined "Medication Administration" policy, (see exhibit 17), a new policy that was created on October 22, 2014 by the Associate Nurse Executive of the parent hospital with approval by the Interim DON, CNO, and Medical Director. This policy describes the transcription and verification process and was implemented October 25, 2014. Educational in-service on this policy was conducted by Interim DON, Interim CE, and PCCs from October 22, 2014 through October 25, 2014, and included all RNs, LPNs, certified nurse assistants (CNAs) and ward clerks (WCs). Two staff members were on vacation during this in-service and completed their education to this policy by October 27, 2014 (see exhibit 5). New or contract staff will receive education to this policy (see exhibit 17) as part of their new employee orientation packet.	

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	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 333	Continued From page 110 Discussed option of hospitalization for more aggressive evaluation of myoclonus [seizure activity] to include possibility of further imaging & neurology eval [evaluation]...somnolence [excessive sleepiness] significantly improved myoclonus now exacerbated [made worse]..." Medical record review of a facility discharge summary dated July 25, 2014, revealed "... Pt discharged to hospital, dx [diagnosis]: accidental overdose..." Resident #457 was admitted to the facility on March 14, 2014, with diagnoses including Acute Venous Embolism and Thrombosis of Lower Extremity, and Fractured Hip. Medical record review of the Hospital Discharge Medication List dated March 14, 2014, revealed "...Enoxaparin [a medication to prevent blood clots]...0.4 ml [milliliters], subcutaneous, every 24 hours..." Medical record review of the Physician's Recapitulation Orders dated March 14, 2014, revealed "...Enoxaparin...40 mg/0.4 ml sol [solution] give 0.4 ml...subcutaneous once a day for blood clotting control..." Medical record review of the Medication Record dated March 14, 2014, through March 20, 2014, revealed resident #457 did not receive Enoxaparin 40 mg subcutaneous on March 15 and March 17, 2014. Medical record review of a Physician's Order dated March 18, 2014, revealed "...Vascular US [ultrasound] RLE [right lower extremity] Dx: warmth, edema [swelling]... Dx: chills, warm,	F 333	This educational material will be updated as policy changes occur by the CE. The CE will also be responsible for educating current RNs, LPNs, CNAs, and WCs of policy changes when they occur. Beginning October 17, 2014, TCC (facility) now receives a printed MAR from the pharmacy every day for the next 24 hour period. These MARs are reviewed by two RN's for accuracy prior to use for medication pass by TCC (facility) nurse. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Beginning October 1, 2014 only RNs have been permitted to transcribe medication and treatment orders. On October 10, 2014, the Hospital Quality Management Department began performing audits (see exhibit 20) of 100% of the facility's residents charts each day to ensure that the following processes are completed: • Verification that 2 RNs have deemed all physician orders accurate for every current resident • 12 hour chart checks are completed on every resident each shift including review of all MARs, TARs, and new physician orders • Two nurses have reviewed every medication administered to every resident If the Quality Management Department finds deficiencies during their audits, they communicate these to the DON. Deviations from these practices as of October 27, 2014 will result in employee re-education and/or disciplinary action by the DON. The TCC Medication Error/Risk Team began on October 6, 2014, and was tasked to evaluate compliance with the process defined in the policy "Medication Administration" (see exhibit 13). This team evaluates all medication error occurrences, and reviews medication error rates in the weekly meeting.	

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	445404	A. BUILDING _____ B. WING _____	10/02/2014

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BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 333	Continued From page 111 swollen RLE..." Medical record review of a Diagnostic Report dated March 19, 2014, revealed "...Exam...Lower Venous Right...Clinical: RLE Edema and Warmth...Findings...Significant nonocclusive thrombus [blood clot] is seen within the right posterior tibial and peroneal veins...Impression: significant nonocclusive thrombus below the knee within the right peroneal and posterior tibial veins..." Medical record review of a Physician's Progress Note dated March 19, 2014, revealed "...results RLE doppler show nonocclusive thrombus below knee [within] right peroneal [and] post tibial veins. Pt has had erythema [redness]/edema x [times] 2 days..." Review of the facility investigation dated March 20, 2014, revealed "...Error when entering order. clicked frequency options and entered every 2 days...suggest to prevent similar occurrences? Read order thoroughly recheck after entered for accuracy..." Review of the facility investigation dated March 21, 2014, revealed "...Event Date: 3/14/2014...Order entry error off admission orders from [named hospital]. WC [ward clerk] changed the frequency of the med dosing which should not have been adjusted. Nurse did not notice the change in time frequencies...Medication involved: Enoxaparin [Lovenox]..." Interview with the CE/QA (Clinical Educator/Quality Assurance) Nurse on September 29, 2014, at 8:30 a.m., in the conference room, confirmed the Lovenox order	F 333	Error rates are determined by the number of medication errors per month divided by the total number of doses administered that month. The goal is to have no medication errors, but in the event an error occurs, this team ensures that a robust investigation and evaluation ensues. The TCC Medication Error/Risk Team meets every Monday at 1:30pm and includes the TCC Medical Director, TCC Administrator, Hospital CMO, Hospital CNO, Consultant Pharmacist, Hospital Associate Nurse Executive, TCC Director of Nursing, TCC PCC, TCC CE, Hospital Risk Manager, and Hospital Quality Management Director. In addition to other responsibilities (see exhibit 13), the Medication Error Team/Risk Team reviews all medication occurrence reports (see exhibit 6), identifies negative trends from the analysis of data we enter in our medication error database, and reviews the Hospital Quality Management audit results weekly. The team will also discuss any Safety Hotline calls made concerning medication errors or medication administration processes at TCC. This Hotline is used to report conditions affecting clinical resident safety or quality of care issues including medication errors or concerns. Calls may be left anonymously or callers may leave contact information. The calls are transcribed by the Quality Management Department at the hospital and reviewed individually by the Hospital Risk Manager and the CMO. The Hospital Safety Hotline phone number is posted in staff work areas. Beginning October 27, 2014, a systematic plan for audit frequency will be followed (see exhibit 21). During the consultant pharmacist's weekly visit, the pharmacist will audit at least 10 residents' MARs for accuracy and completeness of profile. This number was determined based on an average admission volume of about 20 residents per week. The residents audited are chosen with representatives from all units and efforts are made to perform the audits within 7 days of admission. The consultant pharmacist will perform this audit over the next three months. The consultant pharmacist will report audit findings to nursing administration and Director of Pharmacy.	

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F 333	Continued From page 112 was transcribed incorrectly, entered as every other day, and the resident missed the dose on March 15 and 17, 2014. Continued interview confirmed the ward clerk entered the order incorrectly with the frequency of every other day. Interview with NP (Nurse Practitioner) #1 on September 29, 2014, at 11:00 a.m., in the conference room, confirmed it would be possible the missed doses contributed to the development of the blood clot in the leg. Resident #188 was admitted to the facility on March 22, 2014, with diagnoses including Rehabilitation, Dislocated shoulder, Intracranial (Brain) Hemorrhage (bleed), Subdural Hematoma, and Atrial Fibrillation. Medical record review of resident #188's admission orders dated March 22, 2014, revealed "...hold [do not give] Coumadin [an anticoagulant-prolongs blood clotting time] for one month, until cleared by neurosurgery..." Medical record review of the Medication Record dated March 25, 2014, revealed "...Coumadin 2 mg TAB [tablet] (Warfarin Sodium) Oral Every night @ [at] 6 pm for Blood Clotting Control, stop date of March 26, 2014..." Medical record review of the Physician's Orders for Resident #188 revealed no order for Coumadin on March 25, 2014. Medical record review of the MAR dated March 25, 2014, at 6:00 p.m., revealed Licensed Practical Nurse (LPN) #2 administered a Coumadin 2 mg tablet to resident #188.	F 333	The consultant pharmacist, in consultation with the TCC (facility) Medication Error/Risk team will determine the ongoing audit frequency and duration after the initial three (3) month period. The medication transcription audit (see exhibit 22) will include a review for order omissions, dose omissions, duplicate medication orders, transcription errors, and allergies on MAR. The consultant pharmacist will report any irregularities to nursing administration and attending physician.	

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F 333	Continued From page 113	F 333		

Interview with the CE/QA Nurse on September 25, 2014, at 10:55 a.m., in the conference room, confirmed "...the whole thing was done incorrectly, the drug, the dose, and the frequency...we thought the order was entered wrong...we have trouble with the (hospital) orders..."

Interview with LPN #2 on September 29, 2014, at 8:50 a.m., via telephone, confirmed the LPN administered Coumadin 2 mg on March 25, 2014.

Interview with NP #1 on September 29, 2014, at 11:20 a.m., in the conference room, confirmed notice of medication error on March 26, 2014. Further interview confirmed "...I don't review all of the EMARS [Electronic Medication Administration Record] or I would never get done...that is a significant med error..."

Interview with Pharmacy Consultant #1 on September 30, 2014, at 9:30 a.m., in the conference room, confirmed the Coumadin dose was a significant medication error.

Resident #453 was admitted to the facility on February 10, 2014, with diagnoses including Rehabilitation, Aftercare for Healing Traumatic Fracture of Hip, Muscle Weakness, and Spinal Stenosis.

Medical record review of a physician's order dated February 12, 2014, revealed, "...Kcl [potassium] 20 meq [milliequivalent] po [by mouth] x [times] 1..."

Medical record review of the Medication Record dated February 10, 2014, through March 10, 2014, revealed the physician's order was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 333	Continued From page 114	F 333		

transcribed to the Medication Record for medication administration as "...Potassium Chloride 20 meq oral once a day at 0900 (9:00 a.m.) for abnormal labs..." Continued review of the Medication Record revealed the resident was administered Potassium 20 meq every day at 9:00 a.m. for a total of 22 days, (21 doses in error from February 13, 2014, through March 5, 2014).

Interview with the Medical Director on September 29, 2014, at 2:34 p.m., in the conference room, confirmed the resident receiving daily dose of potassium for 22 days, when the original order for potassium was a one time order, was a significant medication error.

The Immediate Jeopardy was effective from February 12 through October 1, 2014, and was removed onsite on October 2, 2014. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the surveyors through review of documents, staff interviews, and observations conducted onsite on October 2, 2014. The surveyors verified the allegation of compliance by:

1. Review of the facility's in-service records to ensure nursing staff were educated regarding changes for medication administration which included the implementation of paper Medication Administration Records (MARs). Review included the facility's plan of action to ensure all nurses were educated on the new system before being allowed to work a shift (coordinated by the Director of Nursing), and the facility's plan for education for nurses who were not scheduled to work or who were on vacation or Family Medical Leave.

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F 333	Continued From page 115	F 333		

2. Verification of the new medication administration system by the facility which included discontinuation of the Electronic Medication Administration Record (EMAR) and implementation of paper Medication Administration Records. Verification included review reconciling new physician's orders and the correct reconciliation to the new paper MARs.
3. Verification through interview with the Director of Nursing and Medical Director, and review of facility documentation all current resident's medication orders were accurately transcribed to paper MARs.
4. Verification through interview with the Administrator, and review of facility documentation the facility's identification of eight transcription errors during the facility's audit of all current resident's medication orders. Review of facility documentation verified residents or resident's family, and physician were notified of the errors. Verification through interview with the Medical Director of immediate intervention to assess resident's status after identification of the error, and provide clarification orders where needed.
5. Review of a random sample of active resident charts to verify the accurate transcription of new physician's orders to the paper MARs. Review of random sample of active resident charts for the completeness and accuracy of 24 hour chart checks.
6. Verification through observation in both nursing stations new orders were being transcribed by Registered Nurses only.
7. Verification through observation of 3 Licensed Practical Nurses (two on the ground floor and one on main floor) of medication administration by Licensed Practical Nurses with the addition of Registered Nurses assisting to ensure the

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F 333	Continued From page 116 accuracy of administered medications. 8. Verification through interviews with nine Registered Nurses, seven Licensed Practical Nurses, and three Ward Clerks/Certified Nursing Assistants to determine the comprehension gained through in-services conducted by the Director of Nursing regarding the changes and implementation of the facility's new transcription and verification procedures. 9. Verification through interview with the Administrator, Medical Director, Chief Nursing Officer, Risk Management Team, Director of Nursing, and Director of the Pharmacy Vendor of their participation in risk management meeting to address the system changes with medication administration, and involvement of all parties in ongoing quality assurance. 10. Verification through observation and interview with ward clerks and registered nurses the facility discontinued the process of entering physician orders electronically by the ward clerks. 11. Verification through observation faxed medication orders were reconciled in real time. 12. Verification by interview with the Director of Pharmacy Vendor the pharmacy consultant will reconcile new medication orders weekly. Non-compliance continues at an "F" level for monitoring the effectiveness of corrective actions and evaluation of monitoring by the Quality Assurance Committee. The facility is required to submit a plan of correction.	F 333		
F 425 SS=L	Complaint # 34603 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency	F 425	F425 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	10/31/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	445404	A. BUILDING _____ B. WING _____	10/02/2014

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F 425	Continued From page 117 drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on review of pharmacy contract, medical record review, review of facility policy and procedures, review of facility investigation, and interview, the facility failed to ensure a system of pharmacy oversight was in place to ensure medication orders were accurately transcribed to the Medication Record, physicians orders were reconciled and verified, and medications were accurately administered according to physician's orders. The failure resulted in medication errors and placed sixteen residents (#262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238) of twenty-four residents reviewed for medication errors in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more	F 425	The medication errors of residents #262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238 have been additionally reviewed by the Transitional Care Center (TCC) (facility) Medical Director and Nursing Leadership Team (created October 7, 2014). The Nursing Leadership Team meets at 8:00am Monday through Friday and is attended by the TCC Administrator, Director of Nursing (DON), Patient Care Coordinators (PCCs), Clinical Educator (CE), and Medical Director at her discretion or as requested. Since it was created the Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and Medical Director have attended daily to ensure the Nursing Leadership Meeting is accomplishing its function. During this meeting, a general review of occurrences including medication errors and ensuring appropriate notification has been completed and is discussed (see exhibit 7). None of the residents suffered a prolonged or permanent condition from the noted medication errors. Each resident was discharged as indicated below: #262 to Blount Memorial Hospital on July 25, 2014. She was discharged from the hospital to a second skilled nursing facility from which she later was discharged to home in good condition. #457 to home on March 31, 2014 #453 to home with Home Health on March 24, 2014 #452 to home on February 21, 2014 #454 to home with Home Health on March 19, 2014 #455 to home with Home Health on April 12, 2014 #456 to an Intermediate Care facility on April 9, 2014 #279 to home with Home Health on May 8, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

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F 425	Continued From page 118 requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death). The facility's failure was likely to place any resident who received medications at risk for immediate jeopardy. The Administrator, Medical Director, Chief Medical Officer/In House Legal Counsel, Chief Nursing Officer, and Director of Nursing were informed of the Immediate Jeopardy on September 30, 2014, at 4:00 p.m., in the conference room. The Immediate Jeopardy was effective February 12, 2014 through October 1, 2014. An extended survey was conducted on September 30, 2014, through October 2, 2014. The facility submitted an Acceptable Allegation of Compliance to the survey team on October 2, 2014. The survey team verified the actions taken by the facility removed the jeopardy on October 2, 2014. Noncompliance continues at the "F" level. The findings included: Review of the facility's contract with the pharmacy, effective June 1, 2010, revealed, "...Duties and Obligation of the Pharmacy...Establish and maintain accurate drug profiles on each resident of Facility...Provide and maintain an appropriate medication administration system...and accessories for such system...Work with Facility to insure that Medical Administration Records, treatment sheets, physician order forms, flow sheets and updates are completed if requested by the Facility...Duties and Obligations of the Facility...Provide Pharmacy	F 425	#111 to home with Home Health on August 10, 2014 #398 to home with Home Health on August 7, 2014 #105 to home with Home Health on August 14, 2014 #197 to home with Home Health on August 8, 2014 #23 to home with Home Health on September 4, 2014 #411 to home on August 29, 2014 #238 to home on September 30, 2014 The TCC (facility) Medical Director determined for resident #188, after she performed additional review of the medical record, the medication dispensing system reports, and pharmacy records, that the resident did not receive Coumadin as documented by the nurse. The nurse entry was inaccurate. This staff member no longer works at TCC (facility). In complete review of chart, there was NO order for Coumadin 2 mg to be given to the resident. However, an electronic request was sent to pharmacy for Coumadin 2 mg. Pharmacy rejected the order due to admission order clarification for "hold Coumadin". They notified TCC (facility) of rejection of order. The pharmacy (which generates Coumadin orders per protocol) did not generate a Coumadin order for this resident. There was no Coumadin withdrawn from the medication dispensing system profile assigned to this resident. The resident was discharged home to Assisted Living with Hospice on April 11, 2014. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 425	Continued From page 119 with all required prescriptions, orders or other approvals required under federal or state law...Be responsible for the administration and documentation regarding the pharmaceuticals in accordance with federal and state law...Clinically monitor its residents' drug therapies at the Facility. Facility will coordinate and communicate with each patient and his/her physicians, pharmacists and other health care pharmacies regarding the patient's needs and care..." Telephone interview with Pharmacy Consultant #1 on September 30, 2014, at 9:30 a.m., confirmed the pharmacy consultant tried to see residents within seven days of admission; performed weekly reviews; and was responsible for reviewing the medications the resident was on for drug interactions. Further interview confirmed the pharmacy consultant did not reconcile the medications with the electronic medication administration record and did not know if the medications were accurately transcribed to the medication administration record. Continued interview confirmed Pharmacy Consultant #1 was notified of a medication error on residents #262, #197, and #188, but was not aware of the extent of those medication errors. Telephone interview with the Pharmacy Director (the Pharmacy also employed the pharmacy consultants) on October 1, 2014, at 9:55 a.m., confirmed the pharmacy consultants had not been reconciling the individual resident medication administration records against the physician's orders with the electronic medication administration record in place. The consultants were only looking for drug interactions and allergies. Continued interview confirmed if the medications were not put into the computer	F 425	All residents in TCC (facility) were considered to have the potential to be affected. The Electronic Medication Administration Record (E-MAR), Electronic Treatment Administration Record (E-TAR), and Electronic Physician Order Entry (E-POE) system was abandoned immediately on September 30, 2014, returning to a hand-written, paper-based MAR, TAR, and physician order system, effective October 1, 2014. On September 30, 2014 through October 1, 2014, charts and MARs of 100% of the current residents (68) were reviewed during our conversion from electronic MAR to paper MAR. In the process, the records were analyzed for any medication errors by the Medical Director who was on site through the entire conversion process. Our initial review identified 7 residents (8 errors) who we thought were affected. However, on further review, one resident (MR# 425745) had previously been notified of the error and another (one of two on MR# 448221) was found not to be an error. The following residents were affected: Resident MR# 475365: Omission of medication on September 14, 2014. Resident MR# 483234: Transcription error on September 18, 2014. Resident MR# 689434: Transcription error on September 25, 2014. Resident MR# 791005: Transcription error on September 23, 2014. Resident: MR# 524029: Transcription error on September 4, 2014. Resident MR# 448221: Transcription error on September 15, 2014. Starting September 30, 2014, additional Registered Nurses (RNs), employed by Parent Hospital (Blount Memorial) were assigned to TCC to complete the following tasks: • Transcribe all physician orders for every current resident to a hand-written MAR and/or TAR on September 30, 2014 for immediate use.	

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	445404	A. BUILDING _____ B. WING _____	10/02/2014

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BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 425	Continued From page 120 system accurately, the pharmacy would not have any knowledge of the inaccuracy. Refer to F157-L, F281-L, F309-L, F333-L. The Immediate Jeopardy was effective from February 12 through October 1, 2014, and was removed onsite on October 2, 2014. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the surveyors through review of documents, staff interviews, and observations conducted onsite on October 2, 2014. The surveyors verified the allegation of compliance by: 1. Review of the facility's in-service records to ensure nursing staff were educated regarding changes for medication administration which included the implementation of paper Medication Administration Records (MARs). Review included the facility's plan of action to ensure all nurses were educated on the new system before being allowed to work a shift (coordinated by the Director of Nursing), and the facility's plan for education for nurses who were not scheduled to work or who were on vacation or Family Medical Leave. 2. Verification of the new medication administration system by the facility which included discontinuation of the Electronic Medication Administration Record (EMAR) and implementation of paper Medication Administration Records. Verification included review reconciling new physician's orders and the correct reconciliation to the new paper MARs.	F 425	• 2 RNs verify accuracy of all physician orders for every current resident to a hand-written MAR and/or TAR after transcription completed on October 1, 2014. • Provide every 12 hour chart checks to include review of all MARs, TARs, and new physician orders effective October 1, 2014. This process is ongoing. • Administer all medications under the purview of two licensed nurses (RN or Licensed Practical Nurse (LPN)) effective October 1, 2014. This process is ongoing. On October 1, 2014, the Clinical Director of the contracted pharmacy was on site at the TCC facility. He worked with the facility's Information Systems team to begin preparation for conversion to a daily printed MAR to replace the handwritten MARs implemented on September 30, 2014. From October 1, 2014 through October 29, 2014 the consultant pharmacist was involved in at least 10 conferences, some on site and some via telephone (see exhibit 25) to assist with evaluation of, changes, and improvements to medication management process. He also participated in refinement of nursing and pharmacy processes, contributed to clarification on the use of certain medications, and assisted in the improvement of communication between facility and pharmacy and provided oversight in implementation of recommended changes (see exhibit 25). He has also been available by phone and email and these modalities were used to contact him on several occasions for various issues and clarifications. From October 1, 2014 through October 16, 2014, the TCC Medical Director, Chief Nursing Officer (CNO), DON, Interim CE, and Clinical Director of the contracted pharmacy developed a process for utilizing a printed MAR established by the Pharmacy. This process is outlined in the new "Medication Administration" policy (see exhibit 17) developed by the Associate Nurse Executive on October 22, 2014, and reviewed and approved by the Interim DON, CNO and Medical Director. This policy was implemented October 25, 2014.	

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F 425	Continued From page 121 3. Verification through interview with the Director of Nursing and Medical Director, and review of facility documentation all current resident's medication orders were accurately transcribed to paper MARs. 4. Verification through interview with the Administrator, and review of facility documentation the facility's identification of eight transcription errors during the facility's audit of all current resident's medication orders. 5. Review of a random sample of active resident charts to verify the accurate transcription of new physician's orders to the paper MARs. Review of random sample of active resident charts for the completeness and accuracy of 24 hour chart checks. 6. Verification through observation in both nursing stations new orders were being transcribed by Registered Nurses only. 7. Verification through observation of 3 Licensed Practical Nurses (two on the ground floor and one on main floor) of medication administration by Licensed Practical Nurses with the addition of Registered Nurses assisting to ensure the accuracy of administered medications. 8. Verification through interviews with nine Registered Nurses, seven Licensed Practical Nurses, and three Ward Clerks/Certified Nursing Assistants to determine the comprehension gained through in-services conducted by the Director of Nursing regarding the changes and implementation of the facility's new transcription and verification procedures. 9. Verification through interview with the Administrator, Medical Director, Chief Nursing Officer, Risk Management Team, Director of Nursing, and Director of the Pharmacy Vendor of their participation in risk management meeting to address the system changes with medication	F 425	Educational inservice on the "Medication Administration" policy (see exhibit 4) was conducted by the Interim DON, Interim CE, and PCCs from October 22, 2014 through October 25, 2014, and included all RNs, LPNs, CNAs, and WCs. Two staff members were on vacation during this in-service and completed the education to this policy by October 27, 2014 (see exhibit 5). New or contract staff will receive education to this policy (see exhibit 17) as part of their new employee orientation packet. This educational material will be updated as policy changes occur by the CE. The CE will also be responsible for educating current RNs, LPNs, CNAs, and WCs of policy changes when they occur. As of October 17, 2014, TCC WCs began faxing all orders to the pharmacy for transcribing on to the new printed version of the residents' MAR. These printed MARs were initiated on October 17, 2014 as well. Pharmacy will maintain an accurate resident profile with the medication orders sent from the TCC (facility). This process will ensure increased oversight by the pharmacy of each resident's MAR. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; Pharmacy will generate a physician order set (see exhibit 26) twice per month and MAR daily from its pharmacy information system for the TCC (facility) to use during medication administration. Educational in-service (see exhibit 4) was conducted by the Interim DON, Interim CE, and PCCs from October 22, 2014 through October 25, 2014, and included all RNs, LPNs, CNAs, and WCs. Copies of the new policy "Medication Administration" (see exhibit 17) and information flyers on the process of faxing physician orders to the pharmacy were distributed and reviewed with the staff by the instructor during these educational sessions and staff questions were answered. Continued On Page 122(a)	

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	445404	A. BUILDING _____ B. WING _____	10/02/2014

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F 425	Continued From page 122	F 425	All clinical staff members were educated by October 25, 2014 except for two staff members who were on vacation during this in-service and those two staff members completed their education to this policy by October 27, 2014 (see exhibit 5). New or contract staff will receive this education as part of their new employee orientation packet. This educational material will be updated as policy changes occur by the CE. The CE will also be responsible for educating current RNs, LPNs, CNAs, and WCs of policy changes when they occur. The Clinical Director of the Contract Pharmacy is now a member of the TCC Medication Error/Risk Team that started on October 6, 2014. The TCC Medication Error/Risk Team meets every Monday at 1:30pm and includes the TCC Medical Director, TCC Administrator, Hospital CMO, Hospital CNO, Consultant Pharmacist, Hospital Associate Nurse Executive, TCC DON, TCC PCC, TCC CE, Hospital Risk Manager, and Hospital Quality Management Director. In addition to other responsibilities (see exhibit 13), the TCC Medication Error Team/Risk Team reviews all medication occurrence reports (see exhibit 6), identifies negative trends from the analysis of data we enter in our medication error database, and reviews the medication transcription audit (see exhibit 22) results. The consultant pharmacist is also a member of the existing Quality Assurance (QA) Committee. This committee meets monthly on the third Wednesday of the month at 11:30am and includes the TCC Administrator, TCC Medical Director, DON, CE, PCCs, Social Services Representative, Registered Dietician (RD), Minimum Data Set (MDS) coordinator, and the pharmacy consultant. The purpose of the QA Committee is to provide general oversight for the quality of care at the facility (see exhibit 14). One responsibility of this committee is the review of medication errors and trends and evaluation of such, and providing recommendations to correct them. The consultant pharmacist is also a member of the existing quarterly TCC Advisory Committee. This committee meets quarterly on the Fourth Wednesday of the month at 7:00am and includes the TCC Administrator, TCC Medical Director,	

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F 425	Continued From page 122 (a)	F 425	DON, CNO, CE, PCCs, Social Services Representative, RD, MDS coordinator, and 2 parent hospital medical staff members (see exhibit 15). In this meeting, the consultant pharmacist summarizes medication utilization, errors, and adverse events. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. During the consultant pharmacist's weekly visit, the pharmacist will audit at least 10 residents' MARs for accuracy and completeness of profile. This number was determined based on an average admission volume of about 20 residents per week. The residents audited are chosen with representatives from all units and efforts are made to perform the audits within 7 days of admission. The consultant pharmacist will perform this audit over the next three months. The consultant pharmacist will report audit findings to nursing administration and Director of Pharmacy. The consultant pharmacist, in consultation with the TCC (facility) Medication Error/Risk team will determine the ongoing audit frequency and duration after the initial three (3) month period. The medication transcription audit (see exhibit 22) will include a review for order omissions, dose omissions, duplicate medication orders, transcription errors, and allergies on MAR. The consultant pharmacist will report any irregularities to nursing administration and attending physician. TCC (facility) RN will notify the pharmacy whenever a medication error is reported. The medication transcription audit (see exhibit 22) will include a review for order omissions, dose omissions, duplicate medication orders, transcription errors, and allergies on MAR. A pharmacist will participate in the TCC Medication Errors/Risk team meetings. The pharmacist will communicate medication management recommendations weekly during the TCC (facility) Medication Error/Risk team and monthly during QA meetings where medication errors and medication reconciliation are discussed.	

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F 425	Continued From page 122 administration. 10. Verification through observation and interview with ward clerks and registered nurses the facility discontinued the process of entering physician orders electronically by the ward clerks. 11. Verification through observation faxed medication orders were reconciled in real time. 12. Verification by interview with the Director of Pharmacy Vendor the pharmacy consultant will reconcile new medication orders weekly. Non-compliance continues at an "F" level for monitoring the effectiveness of corrective actions and evaluation of monitoring by the Quality Assurance Committee. The facility is required to submit a plan of correction. c/o #34603	F 425	Continued From Page 122(b)	
F 428 SS=L	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on review of pharmacy contract, review of facility investigations, medical record review, interview, and review of facility policy, the	F 428	F428 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The medication errors of residents #262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238 have been additionally reviewed by the Transitional Care Center (TCC) (facility) Medical Director and Nursing Leadership Team (created October 7, 2014). The Nursing Leadership Team meets at 8:00am Monday through Friday and is attended by the TCC Administrator, Director of Nursing (DON), Patient Care Coordinators (PCCs), Clinical Educator (CE), and Medical Director at her discretion or as requested. The Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and Medical Director have attended daily to ensure the Nursing Leadership Meeting is accomplishing its function.	10/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 123	F 428	During this meeting, a general review of occurrences including medication errors and ensuring appropriate notification has been completed is discussed (see exhibit 7). None of the residents suffered a prolonged or permanent condition from the noted medication errors.	

pharmacy failed to provide accurate drug regimen reviews to prevent the systemic failure of inaccurate medication transcription and verification of physician orders for medications. The failure resulted in medication errors and placed sixteen residents (#262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238) of twenty-four residents reviewed for medication errors in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death). The facility's failure was likely to place any resident who received medications at risk for Immediate Jeopardy.

The Administrator, Medical Director, Chief Medical Officer/In House Legal Counsel, Chief Nursing Officer, and Director of Nursing were informed of the Immediate Jeopardy on September 30, 2014, at 4:00 p.m., in the conference room.

The Immediate Jeopardy was effective February 12, 2014 through October 1, 2014.

An extended survey was conducted September 30 through October 1, 2014.

The facility submitted an Acceptable Allegation of Compliance to the survey team on October 2, 2014. The survey team verified the actions taken by the facility removed the jeopardy on October 2, 2014. Noncompliance continues at the "F" level.

The findings included:

Review of the facility's contract with the

Each resident was discharged as indicated below:

#262 to Blount Memorial Hospital on July 25, 2014. She was discharged from the hospital to a second skilled nursing facility from which she later was discharged to home in good condition.

#457 to home on March 31, 2014

#453 to home with Home Health on March 24, 2014

#452 to home on February 21, 2014

#454 to home with Home Health on March 19, 2014

#455 to home with Home Health on April 12, 2014

#456 to an Intermediate Care facility on April 9, 2014

#279 to home with Home Health on May 8, 2014

#111 to home with Home Health on August 10, 2014

#398 to home with Home Health on August 7, 2014

#105 to home with Home Health on August 14, 2014

#197 to home with Home Health on August 8, 2014

#23 to home with Home Health on September 4, 2014

#411 to home on August 29, 2014

#238 to home on September 30, 2014 TCC (facility).

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F 428	Continued From page 124 pharmacy, effective June 1, 2010, revealed, "...Duties and Obligation of the Pharmacy...Establish and maintain accurate drug profiles on each resident of Facility...Provide and maintain an appropriate medication administration system...and accessories for such system...Work with Facility to insure that Medical Administration Records, treatment sheets, physician order forms, flow sheets and updates are completed if requested by the Facility...Duties and Obligations of the Facility...Provide Pharmacy with all required prescriptions, orders or other approvals required under federal or state law...Be responsible for the administration and documentation regarding the pharmaceuticals in accordance with federal and state law...Clinically monitor its residents' drug therapies at the Facility. Facility will coordinate and communicate with each patient and his/her physicians, pharmacists and other health care pharmacies regarding the patient's needs and care..." Review of facility investigations for sixteen residents (#262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, and #238) revealed a pattern of medication errors as a result of inaccurate transcription and failure to verify medication records with written physician's orders (medication reconciliation), resulting in errors of medications being administered for the wrong duration, in excessive dosages, omission of medications, and administering medications not prescribed by the physician. Telephone interview with pharmacy consultant #1 on September 25, 2014, at 2:45 p.m., revealed the consultant was aware of the medication error involving resident #262 and resident #197 on July	F 428	The TCC (facility) Medical Director determined for resident #188, after she performed additional review of the medical record, the medication dispensing system reports, and pharmacy records, that the resident did not receive Coumadin as documented by the nurse. The nurse entry was inaccurate. This staff member no longer works at In complete review of chart, there was NO order for Coumadin 2 mg to be given to the resident. However, an electronic request was sent to pharmacy for Coumadin 2 mg. Pharmacy rejected the order due to admission order clarification for "hold Coumadin". They notified TCC (facility) of rejection of order. The pharmacy (which generates Coumadin orders per protocol) did not generate a Coumadin order for this resident. There was no Coumadin withdrawn from the medication dispensing system profile assigned to this resident. The resident was discharged home to Assisted Living with Hospice on April 11, 2014. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents in TCC (facility) were considered to have the potential to be affected. The Electronic Medication Administration Record (E-MAR), Electronic Treatment Administration Record (E-TAR), and Electronic Physician Order Entry (E-POE) system was abandoned immediately on September 30, 2014, returning to a hand-written, paper-based MAR, TAR, and physician order system, effective October 1, 2014. On September 30, 2014 through October 1, 2014, charts and MARs of 100% of the current residents (68) were reviewed during our conversion from electronic MAR to paper MAR. In the process, the records were analyzed for any medication errors by the Medical Director who was on site through the entire conversion process. Our initial review identified 7 residents (8 errors) who we thought were affected. However, on further review, one resident (MR# 425745) had previously been notified of the error and another (one of two on MR# 448221) was found not to be an error. The following residents were affected:	

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F 428	Continued From page 125 25, 2014, and was asked by the facility for drug interaction guidance. The consultant provided drug interaction information to the Clinical Educator/Quality Assurance Nurse and the Director of Nursing. The pharmacy consultant was also aware of a Warfarin medication error with resident #188, but was not aware of the medication errors detailed in the other thirteen facility investigations. The Pharmacy Consultant confirmed the thirteen investigations were not reviewed during the the quarterly advisory board meetings. Telephone interview with Pharmacy Consultant #1 on September 30, 2014, at 9:30 a.m., confirmed the pharmacy consultant did not reconcile the medications with the electronic medication administration record and did not know if the medications prescribed by the physician were accurately transcribed on the medication administration records. Interview with Pharmacy Consultant #1 on September 29, 2014, at 2:35 p.m., in the Clinical Educator/Quality Assurance Nurse's office, confirmed no communication from the facility had been forwarded on the medication errors for residents #457, #453, #452, #454, #455, #456, #279, #111, #398, #105, #23, #411, or #238. The pharmacy consultant stated "...attend quarterly advisory board meetings, last meeting was August 27, 2014, where antidepressants, hypnotics, Coumadin, dosages were discussed, and outliers and percentages of medications within range were discussed..." Refer to F157-L, F281-L, F309-L, F333-K, F425-L The Immediate Jeopardy was effective from	F 428	Resident MR# 475365: Omission of medication on September 14, 2014. Resident MR# 483234: Transcription error on September 18, 2014. Resident MR# 689434: Transcription error on September 25, 2014. Resident MR# 791005: Transcription error on September 23, 2014. Resident: MR# 524029: Transcription error on September 4, 2014. Resident MR# 448221: Transcription error on September 15, 2014. Starting September 30, 2014, additional Registered Nurses (RNs), employed by Parent Hospital (Blount Memorial) were assigned to TCC to complete the following tasks: • Transcribe all physician orders for every current resident to a hand-written MAR and/or TAR on September 30, 2014 for immediate use. • 2 RNs verify accuracy of all physician orders for every current resident to a hand-written MAR and/or TAR after transcription completed on October 1, 2014. • Provide every 12 hour chart checks to include review of all MARs, TARs, and new physician orders effective October 1, 2014. This process is ongoing. • Administer all medications under the purview of two licensed nurses (RN or Licensed Practical Nurse (LPN) effective October 1, 2014. This process is ongoing. On October 1, 2014, the Clinical Director of the contracted pharmacy was on site at the TCC facility. He worked with the facility's Information Systems team to begin preparation for conversion to a daily printed MAR to replace the handwritten MARs implemented on September 30, 2014.	

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BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

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F 428	Continued From page 126 February 12 through October 1, 2014, and was removed onsite on October 2, 2014. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the surveyors through review of documents, staff interviews, and observations conducted onsite on October 2, 2014. The surveyors verified the allegation of compliance by: 1. Review of the facility's in-service records to ensure nursing staff were educated regarding changes for medication administration which included the implementation of paper Medication Administration Records (MARs). Review included the facility's plan of action to ensure all nurses were educated on the new system before being allowed to work a shift (coordinated by the Director of Nursing), and the facility's plan for education for nurses who were not scheduled to work or who were on vacation or Family Medical Leave. 2. Verification of the new medication administration system by the facility which included discontinuation of the Electronic Medication Administration Record (EMAR) and implementation of paper Medication Administration Records. Verification included review reconciling new physician's orders and the correct reconciliation to the new paper MARs. 3. Verification through interview with the Director of Nursing and Medical Director, and review of facility documentation all current resident's medication orders were accurately transcribed to paper MARs. 4. Verification through interview with the Administrator, and review of facility documentation the facility's identification of eight transcription errors during the facility's audit of all	F 428	From October 1, 2014 through October 29, 2014 the consultant pharmacist was involved in at least 10 conferences, some on site and some via telephone (see exhibit 25) to assist with evaluation of, changes, and improvements to medication management process. He also participated in refinement of nursing and pharmacy processes, contributed to clarification on the use of certain medications, and assisted in the improvement of communication between facility and pharmacy and provided oversight in implementation of recommended changes (see exhibit 25). He has also been available by phone and email and these modalities were used to contact him on several occasions for various issues and clarifications. From October 1, 2014 through October 16, 2014, the TCC Medical Director, Chief Nursing Officer (CNO), DON, Interim CE, and Clinical Director of the contracted pharmacy developed a process for utilizing a printed MAR established by the Pharmacy. This process is outlined in the new "Medication Administration" policy (see exhibit 17) developed by the Associate Nurse Executive on October 22, 2014, and reviewed and approved by the Interim DON, CNO and Medical Director. This policy was implemented October 25, 2014. Educational in-service (see exhibit 5)on the "Medication Administration" policy (see exhibit 17) was conducted by the Interim DON, Interim CE, and PCCs from October 22, 2014 through October 25, 2014, and included all RNs, LPNs, CNAs, and WCs. Two staff members were on vacation during this in-service and completed the education to this policy by October 27, 2014 (see exhibit 5). New or contract staff will receive education to this policy (see exhibit 17) as part of their new employee orientation packet. This educational material will be updated as policy changes occur by the CE. The CE will also be responsible for educating current RNs, LPNs, CNAs, and WCs of policy changes when they occur. As of October 17, 2014, TCC WCs began faxing all orders to the pharmacy for transcribing on to the new printed version of the residents' MAR.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING _____ B. WING _____	10/02/2014

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F 428	Continued From page 127 current resident's medication orders. 5. Review of a random sample of active resident charts to verify the accurate transcription of new physician's orders to the paper MARs. Review of random sample of active resident charts for the completeness and accuracy of 24 hour chart checks. 6. Verification through observation in both nursing stations new orders were being transcribed by Registered Nurses only. 7. Verification through observation of 3 Licensed Practical Nurses (two on the ground floor and one on main floor) of medication administration by Licensed Practical Nurses with the addition of Registered Nurses assisting to ensure the accuracy of administered medications. 8. Verification through interviews with nine Registered Nurses, seven Licensed Practical Nurses, and three Ward Clerks/Certified Nursing Assistants to determine the comprehension gained through in-services conducted by the Director of Nursing regarding the changes and implementation of the facility's new transcription and verification procedures. 9. Verification through interview with the Administrator, Medical Director, Chief Nursing Officer, Risk Management Team, Director of Nursing, and Director of the Pharmacy Vendor of their participation in risk management meeting to address the system changes with medication administration. 10. Verification through observation and interview with ward clerks and registered nurses the facility discontinued the process of entering physician orders electronically by the ward clerks. 11. Verification through observation faxed medication orders were reconciled in real time. 12. Verification by interview with the Director of Pharmacy Vendor the pharmacy consultant will	F 428	These printed MARs were initiated on October 17, 2014 as well. Pharmacy will maintain an accurate resident profile with the medication orders sent from the TCC (facility). This process will ensure increased oversight by the pharmacy of each resident's MAR. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; Pharmacy will generate a physician order set (see exhibit 22) twice per month and MAR daily from its pharmacy information system for the TCC (facility) to use during medication administration. Educational in-service (see exhibit 4) was conducted by the Interim DON, Interim CE, and PCCs from October 22, 2014 through October 25, 2014, and included all RNs, LPNs, CNAs, and WCs. Copies of the new policy "Medication Administration" (see exhibit 17) and information flyers on the process of faxing physician orders to the pharmacy were distributed and reviewed with the staff by the instructor during these educational sessions and staff questions were answered. All clinical staff members were educated by October 25, 2014 except for two staff members who were on vacation during this in-service and those two staff members completed their education to this policy by October 27, 2014 (see exhibit 5). New or contract staff will receive this education as part of their new employee orientation packet. This educational material will be updated as policy changes occur by the CE. The CE will also be responsible for educating current RNs, LPNs, CNAs, and WCs of policy changes when they occur. The Clinical Director of the contracted pharmacy is now a member of the TCC Medication Error/Risk Team that started on October 6, 2014. Continued On Page 128(a)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 128	F 428	The TCC Medication Error/Risk Team meets every Monday at 1:30pm and includes the TCC Medical Director, TCC Administrator, Hospital CMO, Hospital CNO, Consultant Pharmacist, Hospital Associate Nurse Executive, TCC DON, TCC PCC, TCC CE, Hospital Risk Manager, and Hospital Quality Management Director. In addition to other responsibilities (see exhibit 13), the TCC Medication Error Team/Risk Team reviews all medication occurrence reports (see exhibit 6), identifies negative trends from the analysis of data we enter in our medication error database, and reviews the medication transcription audit (see exhibit 22) results. The consultant pharmacist is also a member of the existing Quality Assurance (QA) Committee. This committee meets monthly on the third Wednesday of the month at 11:30am and includes the TCC Administrator, TCC Medical Director, DON, CE, PCCs, Social Services Representative, Registered Dietician (RD), Minimum Data Set (MDS) coordinator, and the pharmacy consultant. The purpose of the QA Committee is to provide general oversight for the quality of care at the facility (see exhibit 14). One responsibility of this committee is the review of medication errors and trends and evaluation of such, and providing recommendations to correct them. The consultant pharmacist is also a member of the existing quarterly TCC Advisory Committee. This committee meets quarterly on the Fourth Wednesday of the month at 7:00am and includes the TCC Administrator, TCC Medical Director, DON, CNO, CE, PCCs, Social Services Representative, RD, MDS coordinator, and 2 parent hospital medical staff members (see exhibit 15). In this meeting, the consultant pharmacist summarizes medication utilization, errors, and adverse events.	

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F 428	Continued From page 128 (a)	F 428	How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. During the consultant pharmacist's weekly visit, the pharmacist will audit at least 10 residents' MARs for accuracy and completeness of profile. This number was determined based on an average admission volume of about 20 residents per week. The residents audited are chosen with representatives from all units and efforts are made to perform the audits within 7 days of admission. The consultant pharmacist will perform this audit over the next three months. The consultant pharmacist will report audit findings to nursing administration and Clinical Director of the contracted Pharmacy. The consultant pharmacist, in consultation with the TCC (facility) Medication Error/Risk team will determine the ongoing audit frequency and duration after the initial three (3) month period. The medication transcription audit (see exhibit 22) will include a review for order omissions, dose omissions, duplicate medication orders, transcription errors, and allergies on MAR. The consultant pharmacist will report any irregularities to nursing administration and attending physician. TCC (facility) RN will notify the pharmacy whenever a medication error is reported. The medication transcription audit (see exhibit 22) will include a review for order omissions, dose omissions, duplicate medication orders, transcription errors, and allergies on MAR. A pharmacist will participate in the TCC Medication Errors/Risk team meetings. The pharmacist will communicate medication management recommendations weekly during the TCC (facility) Medication Error/Risk team and monthly during QA meetings where medication errors and medication reconciliation are discussed.	

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F 428	Continued From page 128 reconcile new medication orders weekly. Non-compliance continues at an "F" level for monitoring the effectiveness of corrective actions and evaluation of monitoring by the Quality Assurance Committee. The facility is required to submit a plan of correction. c/o #34603	F 428	Continued From 128(b)	
F 490 SS=L	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy and procedures review, review of facility investigations, and interview, the facility failed to be administered in a manner to ensure residents were free of medication errors. The facility's failure to address systemic failures for medication administration placed sixteen residents (#262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238) of twenty-four residents reviewed for medication errors in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death). The facility's failure was likely to place any resident who received medications at risk for immediate jeopardy.	F 490	F490 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The medication errors of residents #262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238 have been additionally reviewed by the Transitional Care Center (TCC) (facility) Medical Director and Nursing Leadership Team (created October 7, 2014). The Nursing Leadership Team meets at 8:00am Monday through Friday and is attended by the TCC Administrator, Director of Nursing (DON), Patient Care Coordinators (PCCs), Clinical Educator (CE), and Medical Director at her discretion or as requested. The Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and Medical Director have attended daily to ensure the Nursing Leadership Meeting is accomplishing its function. During this meeting, a general review of occurrences including medication errors and ensuring appropriate notification is discussed (see exhibit 7). None of the residents suffered a prolonged or permanent condition from the noted medication errors. Each resident was discharged as indicated below: #262 to Blount Memorial Hospital on July 25, 2014. She was discharged from the hospital to a second skilled nursing facility from which she later was discharged to home in good condition.	10/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 490	Continued From page 129 The Administrator, Medical Director, Chief Medical Officer/In House Legal Counsel, Chief Nursing Officer, and Director of Nursing were informed of the Immediate Jeopardy on September 30, 2014, at 4:00 p.m., in the conference room. The Immediate Jeopardy was effective February 12, 2014 through October 1, 2014. An extended survey was conducted on September 30, to October 2, 2014. The facility submitted an Acceptable Allegation of Compliance to the survey team on October 2, 2014. The survey team verified the actions taken by the facility removed the jeopardy on October 2, 2014. Noncompliance continues at the "F" level. The findings included: Interview with the Administrator on September 30, 2014, at 10:12 a.m., in the conference room, revealed the Administrator was aware of medication errors. Continued interview revealed the Administrator stated the medication errors were more of an individual problem, and "...have been handled on an individual basis..." Further interview revealed the Administrator stated there was a problem in the three step process of transcription and verification of physician's orders (#1. The ward clerk transcribing physician's orders correctly from the paper orders into the electronic MAR, #2. The RN checking to verify the orders were correct, and #3. The Night Shift RN Checklist double-checking for any transcription errors). Further interview revealed, "...I don't think we have come down to a clear	F 490	#457 to home on March 31, 2014 #453 to home with Home Health on March 24, 2014 #452 to home on February 21, 2014 #454 to home with Home Health on March 19, 2014 #455 to home with Home Health on April 12, 2014 #456 to an Intermediate Care facility on April 9, 2014 #279 to home with Home Health on May 8, 2014 #111 to home with Home Health on August 10, 2014 #398 to home with Home Health on August 7, 2014 #105 to home with Home Health on August 14, 2014 #197 to home with Home Health on August 8, 2014 #23 to home with Home Health on September 4, 2014 #411 to home on August 29, 2014 #238 to home on September 30, 2014 The TCC (facility) Medical Director determined for resident #188, after she performed additional review of the medical record, the medication dispensing system reports, and pharmacy records, that the resident did not receive Coumadin as documented by the nurse. The nurse entry was inaccurate. This staff member no longer works at TCC (facility). In complete review of chart, there was NO order for Coumadin 2 mg to be given to the resident. However, an electronic request was sent to pharmacy for Coumadin 2 mg.	

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F 490	Continued From page 130 answer...I don't know the root cause of the problem..." The Administrator stated individual nurses who made the medication errors not being informed/re-educated was "...a problem..." Further interview confirmed the Administrator had not identified a trend with the repeated occurrence of medication errors. Refer to F157-L, F281-L, F309-L, F333-L, F425-L, F428-L The Immediate Jeopardy was effective from February 12 through October 1, 2014, and was removed onsite on October 2, 2014. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the surveyors through review of documents, staff interviews, and observations conducted onsite on October 2, 2014. The surveyors verified the allegation of compliance by: 1. Review of the facility's in-service records to ensure nursing staff were educated regarding changes for medication administration which included the implementation of paper Medication Administration Records (MARs). Review included the facility's plan of action to ensure all nurses were educated on the new system before being allowed to work a shift (coordinated by the Director of Nursing), and the facility's plan for education for nurses who were not scheduled to work or who were on vacation or Family Medical Leave. 2. Verification of the new medication administration system by the facility which included discontinuation of the Electronic Medication Administration Record (EMAR) and implementation of paper Medication	F 490	Pharmacy rejected the order due to admission order clarification for "hold Coumadin". They notified TCC (facility) of rejection of order. The pharmacy (which generates Coumadin orders per protocol) did not generate a Coumadin order for this resident. There was no Coumadin withdrawn from the medication dispensing system profile assigned to this resident. The resident was discharged home to Assisted Living with Hospice on April 11, 2014. The Administrator has received disciplinary action October 24, 2014 in the form of probation. The details of this action are on file for review. The DON was suspended on October 10, 2014 and, as of October 17, 2014 was no longer employed at TCC (facility). The CE was suspended October 10, 2014 and, as of October 17, 2014 was no longer employed at TCC (facility). The CNO and a Clinical Director from Blount Memorial Hospital provided nursing clinical leadership until the interim DON and the interim CE were appointed on October 17, 2014. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents in the TCC (facility) were considered to have the potential to be affected. The Electronic Medication Administration Record (E-MAR), Electronic Treatment Administration Record (E-TAR), and Electronic Physician Order Entry (E-POE) system was abandoned immediately on September 30, 2014, returning to a hand-written, paper-based MAR, TAR, and physician order system, effective October 1, 2014. On September 30, 2014 through October 1, 2014, charts and medication administration records (MARs) of 100% of the current residents (68) were reviewed during our conversion from electronic MAR to paper MAR. In the process, the records were analyzed for any medication errors by the Medical Director who was on site through the entire conversion process. Our initial review identified 7 residents (8 errors) who we thought were affected.	

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F 490	Continued From page 131 Administration Records. Verification included review reconciling new physician's orders and the correct reconciliation to the new paper MARs. 3. Verification through interview with the Director of Nursing and Medical Director, and review of facility documentation all current resident's medication orders were accurately transcribed to paper MARs. 4. Verification through interview with Director of Nursing and review of the Medication Occurrence Report modified to require the date and time of notification of resident and/or family of medication errors. 5. Verification through interview with the Administrator, and review of facility documentation the facility's identification of eight transcription errors during the facility's audit of all current resident's medication orders. Review of facility documentation verified residents or resident's family, and physician were notified of the errors. Verification through interview with the Medical Director of immediate intervention to assess resident's status after identification of the error, and provide clarification orders where needed. 6. Review of a random sample of active resident charts to verify the accurate transcription of new physician's orders to the paper MARs. Review of random sample of active resident charts for the completeness and accuracy of 24 hour chart checks. 7. Verification through observation in both nursing stations new orders were being transcribed by Registered Nurses only. 8. Verification through observation of 3 Licensed Practical Nurses (two on the ground floor and one on main floor) of medication administration by Licensed Practical Nurses with the addition of Registered Nurses assisting to ensure the	F 490	However, on further review, one resident (MR# 425745) had previously been notified of the error and another (one of two on MR# 448221) was found not to be an error. The following residents were affected: Resident MR# 475365: Omission of medication on September 14, 2014. Resident MR# 483234: Transcription error on September 18, 2014. Resident MR# 689434: Transcription error on September 25, 2014. Resident MR# 791005: Transcription error on September 23, 2014. Resident: MR# 524029: Transcription error on September 4, 2014. Resident MR# 448221: Transcription error on September 15, 2014. Starting September 30, 2014, additional Registered Nurses (RNs), employed by Parent Hospital (Blount Memorial) were assigned to the TCC to complete the following tasks: • Transcribe all physician orders for every current resident to a hand-written MAR and/or TAR on September 30, 2014 for use on October 1, 2014 • Verify (2 RNs) accuracy of all physician orders for every current resident to a hand-written MAR and/or TAR after transcription completed on October 1, 2014. Continued On Page 132(a)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 490	Continued From page 132	F 490	• Provide every 12 hour chart checks to include review of all MARs, TARs, and new physician orders effective October 1, 2014. This process is ongoing. • Administer all medications under the purview of two licensed nurses (RN or Licensed Practical Nurse (LPN)) effective October 1, 2014. This process is ongoing. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; Initial education on the transcription and verification process (see exhibit 16) was completed by the CNO on September 30, 2014 during a face to face educational session with all RNs and LPNs present that shift. For the subsequent shifts on September 30, 2014 and October 1, 2014, the Director of Nursing reviewed the Allegation of Compliance and the process for transcribing and verifying MARs and TARs, chart check process, and new medication occurrence report, with each shift's RNs and LPNs (see exhibit 16). From October 1, 2014 through October 16, 2014 the TCC Medical Director, CNO, Interim DON, Interim CE, and Clinical Director of the contract pharmacy developed a process for utilizing a printed MAR established by the pharmacy. Beginning on October 17, 2014 the TCC (facility) now receives a printed MAR from the pharmacy every day for the next 24 hour period. These MARs are reviewed by two RNs for accuracy prior to use for medication pass by TCC (facility) nurses (RNs or LPNs). This process is outlined in the "Medication Administration" policy (see exhibit 17). This policy was a new policy that was created, reviewed, and discussed on October 22, 2014 with approval by the Interim DON, CNO, Associate Nurse Executive, and Medical Director and this policy describes the transcription and verification process. This policy was implemented October 25, 2014.	

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F 490	Continued From page 132 (a)	F 490	Educational in-service (see exhibit 4) on the "Medication Administration" policy was conducted by Interim DON, Interim CE, and PCCs from October 22, 2014 through October 25, 2014, and included all RNs, LPNs, Certified Nurse Assistants (CNAs), and Ward Clerks (WCs). Two staff members were on vacation during this in-service and completed their education (see exhibit 5) to this policy by October 27, 2014. New or contract staff will receive education to this policy (see exhibit 17) as part of their new employee orientation packet. This educational material will be updated as policy changes occur by the CE. The CE will also be responsible for educating current RNs, LPNs, CNAs, and WCs of policy changes when they occur. In accordance with standards of professional nursing practice as set forth in the "Lippincott Manual of Nursing Practice, 10th Edition, 2014," nursing staff has been educated to adhere to TCC (facility) policies and procedures regarding medication transcription, verification, administration, and error reporting. Education was conducted October 22, 2014 through October 25, 2014. It was administered by the CE, the Interim DON, and the PCCs. Education was provided to RNs, LPNs, CNAs, and WCs who were required to indicate understanding of educational materials via their signature. Materials provided to nursing staff included the Nursing Education Packet (see exhibit 4) and clarification and instructional memos (see exhibit 18). The week of October 27, 2014 a separate RN education packet (see exhibit 19) was provided for clarification and reinforcement of previous education. The DON is directly responsible for ensuring appropriate adherence of nursing personnel to policy. A contract with an experienced, qualified Licensed Nursing Home Administrator was executed on October 24, 2014, for the purpose of providing consultative services to the TCC (facility) and to mentor and provide oversight to the current Administrator. This consultant was on site as of October 29, 2014. The consultant will be on site 8 hours a day, 5 days a week. He will evaluate the current Administrator which consists of putting forward recommendations to improve the Administrator's effectiveness. This evaluation	

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F 490	Continued From page 132 (b)	F 490	will take place over a maximum of 60 days. During that time, weekly meetings will occur with the CNO, the consultant, and the Administrator to review that week's performance (see exhibit 27). The purpose of the consultant's evaluation is to ensure that the current Administrator can effectively carry out the duties of the on site Licensed Nursing Home Administrator. If the consultant and the CNO do not feel, at the end of the evaluation period, that the current Administrator can effectively perform these duties, a new highly qualified Administrator will be hired. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Beginning October 1, 2014 only RNs have been permitted to transcribe medication and treatment orders. On October 10, 2014, Hospital Quality Management Department began performing audits (see exhibit 20) of 100% of the facility's residents' charts each day to ensure that the following processes are completed: • Verification that 2 RNs have deemed all physician orders accurate for every current resident • 12 hour chart checks are completed on every resident each shift including review of all MARs, TARs, and new physician orders • Two licensed nurses have reviewed every medication administered to every resident If the Quality Management Department finds deficiencies during their audits, they communicate these to the DON. Deviations from these practices as of October 27, 2014 will result in employee re-education and/or disciplinary action by the DON.	

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	445404	A. BUILDING_____ B. WING_____	10/02/2014

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 490	Continued From page 132 (c)	F 490	The TCC Medication Error/Risk Team began on October 6, 2014, and was tasked to evaluate compliance with the process defined in the policy "Medication Administration" (see exhibit 17). This team evaluates all medication error occurrences, and reviews medication error rates in the weekly meeting. Error rates are determined by the number of medication errors per month divided by the total number of doses administered that month. The goal is to have no medication errors, but in the event an error occurs, this team ensures that a robust investigation and evaluation ensues. The TCC Medication Error/Risk Team meets every Monday at 1:30pm and includes the TCC Medical Director, TCC Administrator, Hospital CMO, CNO, Consultant Pharmacist, Hospital Associate Nurse Executive, TCC DON, TCC PCC, TCC CE, Hospital Risk Manager, and Hospital Quality Management Director. In addition to other responsibilities (see exhibit 13), the Medication Error Team/Risk Team reviews all medication occurrence reports (see exhibit 6), identifies negative trends from the analysis of data we enter in our medication error database, and reviews the Hospital Quality Management audit results weekly. The team will also discuss any Safety Hotline calls made concerning medication errors or medication administration processes at TCC. This Hotline is used to report conditions affecting clinical resident safety or quality of care issues including medication errors or concerns. Calls may be left anonymously or callers may leave contact information. The calls are transcribed by the Quality management Department at the hospital and reviewed individually by the Hospital Risk Manager and the CMO. The Hospital Safety Hotline phone number is posted in staff work areas. Beginning October 27, 2014, a systematic plan for audit frequency will be followed (see exhibit 21).	

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F 490	Continued From page 132 (d)	F 490	The contracted Licensed Nursing Home Administrator will evaluate the current Administrator which consists of putting forward recommendations to improve the Administrator's effectiveness. This evaluation will take place over a maximum of 60 days. During that time, weekly meetings will occur with the CNO, the consultant, and the Administrator to review that week's performance (see exhibit 27). The purpose of the consultant's evaluation is to ensure that the current Administrator can effectively carry out the duties of the on site Licensed Nursing Home Administrator. If the consultant and the CNO do not feel, at the end of the evaluation period, that the current Administrator can effectively perform these duties, a new highly qualified Administrator will be hired.	

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F 490	Continued From page 132 accuracy of administered medications. 9. Verification through interviews with nine Registered Nurses, seven Licensed Practical Nurses, and three Ward Clerks/Certified Nursing Assistants to determine the comprehension gained through in-services conducted by the Director of Nursing regarding the changes and implementation of the facility's new transcription and verification procedures. 10. Verification through interview with the Administrator, Medical Director, Chief Nursing Officer, Risk Management Team, Director of Nursing, and Director of the Pharmacy Vendor of their participation in risk management meeting to address the system changes with medication administration, and involvement of all parties in ongoing quality assurance. 11. Verification through observation and interview with ward clerks and registered nurses the facility discontinued the process of entering physician orders electronically by the ward clerks. 12. Verification through observation faxed medication orders were reconciled in real time. 13. Verification by interview with the Director of Pharmacy Vendor the pharmacy consultant will reconcile new medication orders weekly. Non-compliance continues at an "F" level for monitoring the effectiveness of corrective actions and evaluation of monitoring by the Quality Assurance Committee. The facility is required to submit a plan of correction.	F 490	Continued From Page 132(e)	
F 493 SS=L	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing	F 493	F493 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	10/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 493	Continued From page 133 and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigations, review of facility policy and procedures, and interview the facility Governing Body failed to ensure facility policies for accurate medication administration were implemented, and failed to identify a systemic problem of medication errors related to failure to follow policies. The failure placed sixteen residents (#262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238) of twenty-four residents reviewed for medication errors in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death). The facility's failure was likely to place any resident who received medications at risk for Immediate Jeopardy. The Administrator, Medical Director, Chief Medical Officer/In House Legal Counsel, Chief Nursing Officer, and Director of Nursing were informed of the Immediate Jeopardy on September 30, 2014, at 4:00 p.m., in the conference room. The Immediate Jeopardy was effective February 12, 2014 through October 1, 2014.	F 493	The medication errors of residents #262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238 have been additionally reviewed by the Transitional Care Center (TCC) (facility) Medical Director and Nursing Leadership Team (created October 7, 2014). #197 to home with Home Health on August 8, 2014 #23 to home with Home Health on September 4, 2014 #411 to home on August 29, 2014 #238 to home on September 30, 2014 The TCC (facility) Medical Director determined for resident #188, after she performed additional review of the medical record, the medication dispensing system reports, and pharmacy records, that the resident did not receive Coumadin as documented by the nurse. The nurse entry was inaccurate. This staff member no longer works at TCC (facility). The Nursing Leadership Team meets at 8:00am Monday through Friday and is attended by the TCC Administrator, Director of Nursing (DON), Patient Care Coordinators (PCCs), Clinical Educator (CE), and Medical Director at her discretion or as requested. Since it was created, the Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and Medical Director have attended daily to ensure the Nursing Leadership Meeting is accomplishing its function. During this meeting, a general review of occurrences including medication errors and ensuring appropriate notification has been completed is discussed (see exhibit 7). None of the residents suffered a prolonged or permanent condition from the noted medication errors. Each resident was discharged as indicated below: #262 to Blount Memorial Hospital on July 25, 2014. She was discharged from the hospital to a second skilled nursing facility from which she later was discharged to home in good condition.	

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F 493	Continued From page 134 An extended survey was conducted on September 30, to October 2, 2014. The facility submitted an Acceptable Allegation of Compliance to the survey team on October 2, 2014. The survey team verified the actions taken by the facility removed the jeopardy on October 2, 2014. Noncompliance continues at the "F" level. The findings included: Interviews with the Chief Nursing Officer and the Chief Medical Officer/In House Legal Counsel of a local hospital, during the survey, revealed the local hospital owned, and was responsible for Administration and Governing of the facility. Interview with the Chief Nursing Officer (CNO) of the hospital on September 30, 2014, at 5:53 p.m., in the conference room, revealed the Chief Nursing Officer is one of several members of the Steering Committee of the hospital which reviewed medication errors reported to the hospital by the facility. Continued interview with the CNO confirmed the hospital's Steering Committee conducted a root-cause analysis of the medication error of resident #262, and the committee discussed some interventions which needed to be implemented to address the specific issue with resident #262. Continued interview confirmed the CNO was not aware of the scope and extent of the repeated medication errors. Interview with members of the hospital's Risk Management Team: Chief Nursing Officer, Director of Quality Management, and Risk Manager, on October 1, 2014, at 8:45 a.m., in the conference room, revealed the facility's process	F 493	#457 to home on March 31, 2014 #453 to home with Home Health on March 24, 2014 #452 to home on February 21, 2014 #454 to home with Home Health on March 19, 2014 #455 to home with Home Health on April 12, 2014 #456 to an Intermediate Care facility on April 9, 2014 #279 to home with Home Health on May 8, 2014 #111 to home with Home Health on August 10, 2014 #398 to home with Home Health on August 7, 2014 #105 to home with Home Health on August 14, 2014 In complete review of chart, there was NO order for Coumadin 2 mg to be given to the resident. However, an electronic request was sent to pharmacy for Coumadin 2 mg. Pharmacy rejected the order due to admission order clarification for "hold Coumadin". They notified TCC (facility) of rejection of order. The pharmacy (which generates Coumadin orders per protocol) did not generate a Coumadin order for this resident. There was no Coumadin withdrawn from the medication dispensing system profile assigned to this resident. The resident was discharged home to Assisted Living with Hospice on April 11, 2014. A summary of medication occurrences was presented at the monthly Transitional Care Center (TCC) Quality Assurance (QA) meeting.	

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F 493 Continued From page 135

of notifying the hospital of medication errors was by the facility's staff entering medication error reports into a computerized tracking system for the hospital. Continued interview confirmed the medication error reports are reviewed by the Risk Manager, however in-depth, root-cause analysis occurs only in specific cases. Further interview with the Risk Management Team confirmed the Risk Management Team had not identified any trends related to the facility's medication administration processes.

Interview with the Patient Safety Officer of the hospital on October 1, 2014, at 10:50 a.m., in the conference room, revealed the Patient Safety Officer had conducted root cause analysis of specific, individualized medication errors (resident #262) and had identified "...some opportunity at many levels..." of the facility's medication administration system. Continued interview confirmed the Patient Safety Officer had only focused on one resident (#262) to complete a root-cause analysis. Further interview with the Patient Safety Officer confirmed the Patient Safety Officer had not identified, and was not aware of any trends related to the facility's systemic problems with medication administration.

Interview with the Chief Medical Officer of the hospital on October 2, 2014, at 8:20 a.m., in the conference room, confirmed the Chief Medical Officer of the hospital was the presiding chair of the Risk Management committee. Continued interview with the Chief Medical Officer confirmed was aware of "...some of the medication errors..." Further interview confirmed the Chief Medical Officer was not aware "...of the extent and number..." of medication errors and was not

F 493 This team meets monthly on the third Wednesday of the month at 11:30am and includes the TCC Administrator, TCC Medical Director, Director of Nursing (DON), Clinical Educator (CE), Patient Care Coordinators (PCCs), Social Services Department representative, Registered Dietician (RD), Minimum Data Set (MDS) coordinator, and the Pharmacy Consultant. The purpose of the QA Committee is to provide general oversight for the quality of care at the facility (see exhibit 14).

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

All residents in the TCC (facility) were considered to have the potential to be affected. The Electronic Medication Administration Record (E-MAR), Electronic Treatment Administration Record (E-TAR), and Electronic Physician Order Entry (E-POE) system was abandoned immediately on September 30, 2014, returning to a hand-written, paper-based MAR, TAR, and physician order system, effective October 1, 2014. On September 30, 2014 through October 1, 2014, charts and MARs of 100% of the current residents (68) were reviewed during our conversion from electronic MAR to paper MAR. In the process, the records were analyzed for any medication errors by the Medical Director who was on site through the entire conversion process.

Our initial review identified 7 residents (8 errors) who we thought were affected. However, on further review, one resident (MR# 425745) had previously been notified of the error and another (one of two on MR# 448221) was found not to be an error. The following residents were affected:

Resident MR# 475365: Omission of medication on September 14, 2014.

Resident MR# 483234: Transcription error on September 18, 2014.

Resident MR# 689434: Transcription error on September 25, 2014.

Resident MR# 791005: Transcription error on September 23, 2014.

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F 493	Continued From page 136 aware of the facility's repeated pattern of medication errors. Refer to F157-L, F281-L, F309-L, F333-L, F425-L, F428-L, F F490-L The Immediate Jeopardy was effective from February 12 through October 1, 2014, and was removed onsite on October 2, 2014. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the surveyors through review of documents, staff interviews, and observations conducted onsite on October 2, 2014. The surveyors verified the allegation of compliance by: 1. Review of the facility's in-service records to ensure nursing staff were educated regarding changes for medication administration which included the implementation of paper Medication Administration Records (MARs). Review included the facility's plan of action to ensure all nurses were educated on the new system before being allowed to work a shift (coordinated by the Director of Nursing), and the facility's plan for education for nurses who were not scheduled to work or who were on vacation or Family Medical Leave. 2. Verification of the new medication administration system by the facility which included discontinuation of the Electronic Medication Administration Record (EMAR) and implementation of paper Medication Administration Records. Verification included review reconciling new physician's orders and the correct reconciliation to the new paper MARs. 3. Verification through interview with the Director of Nursing and Medical Director, and review of	F 493	Resident: MR# 524029: Transcription error on September 4, 2014. Resident MR# 448221: Transcription error on September 15, 2014. Starting September 30, 2014, additional Registered Nurses (RNs), employed by Parent Hospital (Blount Memorial) were assigned to the TCC to complete the following tasks: • Transcribe all physician orders for every current resident to a hand-written MAR and/or TAR on September 30, 2014 for use on October 1, 2014 • Verify (2 RNs) accuracy of all physician orders for every current resident to a hand-written MAR and/or TAR after transcription completed on October 1, 2014. • Provide every 12 hour chart checks to include review of all MARs, TARs, and new physician orders effective October 1, 2014. This process is ongoing. • Administer all medications under the purview of two licensed nurses (RN or Licensed Practical Nurse (LPN)) effective October 1, 2014. This process is ongoing. The TCC Medication Error/Risk Team (see exhibit) began meeting on October 6, 2014 and is inclusive of the TCC Medical Director, TCC Administrator, Hospital CMO, Hospital CNO, Consultant Pharmacist, Hospital Associate Nurse Executive, TCC DON, TCC PCCs, TCC CE, Hospital Risk Manager, and Hospital Quality Management Director review all occurrences weekly. The CMO, CNO, Hospital Director of Quality Management, and the Hospital Risk Manager also serve on the Hospital Risk Team, which also meets weekly. The TCC Medication Error/Risk Team functions as an independent committee reporting its findings to the parent hospital and the QA committee to enhance its ability to better identify negative patterns or trends involving any adverse occurrence.	

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F 493	Continued From page 137 facility documentation all current resident's medication orders were accurately transcribed to paper MARs. 4. Verification through interview with Director of Nursing and review of the Medication Occurrence Report modified to require the date and time of notification of resident and/or family of medication errors. 5. Verification through interview with the Administrator, and review of facility documentation the facility's identification of eight transcription errors during the facility's audit of all current resident's medication orders. Review of facility documentation verified residents or resident's family, and physician were notified of the errors. Verification through interview with the Medical Director of immediate intervention to assess resident's status after identification of the error, and provide clarification orders where needed. 6. Review of a random sample of active resident charts to verify the accurate transcription of new physician's orders to the paper MARs. Review of random sample of active resident charts for the completeness and accuracy of 24 hour chart checks. 7. Verification through observation in both nursing stations new orders were being transcribed by Registered Nurses only. 8. Verification through observation of 3 Licensed Practical Nurses (two on the ground floor and one on main floor) of medication administration by Licensed Practical Nurses with the addition of Registered Nurses assisting to ensure the accuracy of administered medications. 9. Verification through interviews with nine Registered Nurses, seven Licensed Practical Nurses, and three Ward Clerks/Certified Nursing Assistants to determine the comprehension	F 493	In addition, the CMO serves as Chairman for both of these teams and will provide a summary of issues monthly for the Governing Board (Blount Memorial Hospital Board of Directors) as indicated. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; The process now is that the Nursing Leadership Team reviews all occurrences daily and the TCC Medication Error/Risk Team reviews all occurrences weekly. The Nursing Leadership Meeting occurs at 8:00am Monday through Friday and is attended by the TCC Administrator, DON, PCCs, CE, and Medical Director at her discretion or as requested. During this meeting, a general review of occurrences including medication errors and ensuring appropriate notification has been completed is discussed (see exhibit 7). Weekend occurrences are reviewed on Monday. The TCC Medication Error/Risk Team meets every Monday at 1:30pm and includes the TCC Medical Director, TCC Administrator, Hospital Chief Medical Officer (CMO), Hospital Chief Nursing Officer (CNO), Consultant Pharmacist, Hospital Associate Nurse Executive, TCC DON, TCC PCC, TCC CE, Hospital Risk Manager, and Hospital Quality Management Director. In addition to other responsibilities (see exhibit 13), the Medication Error Team/Risk Team reviews all medication occurrence reports (see exhibit 6), identifies negative trends from the analysis of data we enter in our medication error database, and reviews the Hospital Quality Management audit results weekly. The team will also discuss any Safety Hotline calls made concerning medication errors or medication administration processes at TCC. This Hotline is used to report conditions affecting clinical resident safety or quality of care issues including medication errors or concerns. Calls may be left anonymously or callers may leave contact information. Continued On Page 138(a)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 493	Continued From page 138	F 493	The calls are transcribed by the Quality Management Department at the hospital and reviewed individually by the Hospital Risk Manager and the CMO. The Hospital Safety Hotline phone number is posted in staff work areas. All medication errors are being reported to the TCC Medication Error/Risk Team (see exhibit 13) weekly. This team is reviewing and will continue to review all medication errors at the TCC (facility), all occurrences such as falls or allegations of abuse, and any other pertinent issues identified from the prior week. The review involves discussing the events of the occurrence, reviewing whether or not correct procedure as defined in policy was followed, and reviewing any additional factors or circumstances that may have contributed to the occurrence (for example personnel training and experience, technology). The team identifies trends and determines the best course of action for each error or issue, including education, further analysis, process change or disciplinary action. The team has the authority to make these decisions at the time the occurrence is reviewed and implement change immediately. The team also follows up each change to ensure it has been implemented and is effective. The TCC Medication Error/Risk Team functions as an independent committee reporting its findings to the parent hospital and the QA committee to enhance its ability to better identify negative patterns or trends involving any adverse occurrence. Identification of trends will enhance the QA committee's effectiveness. The TCC (facility) Medical Director actively participates in the governance process of the parent hospital as evidenced by her role as Chief of Staff at the parent hospital (Blount Memorial) for the next two years and her monthly participation in the parent hospital's Board of Director's meetings.	

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F 493	Continued From page 138 (a)	F 493	In addition, significant errors (actual significant harm done or potential for significant harm) are reported by the CMO to the Hospital Board of Directors each month. Additionally the CNO, Quality Management Director, and Risk Manager who attend the TCC Medication Error/ Risk Team also attend the Hospital Board of Directors meeting. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. All medication errors are being reported to the TCC Medication Error/Risk Team (see exhibit 13) weekly. This team is reviewing and will continue to review all medication errors at the TCC (facility), all occurrences such as falls or allegations of abuse, and any other pertinent issues identified from the prior week. The review involves discussing the events of the occurrence, reviewing whether or not correct procedure as defined in policy was followed, and reviewing any additional factors or circumstances that may have contributed to the occurrence (for example personnel training and experience, technology). The team identifies trends and determines the best course of action for each error or issue, including education, further analysis, process change or disciplinary action. Starting October 16, 2014, additional data fields have been added to the occurrence tracking system that will enable trending of medication error details by employee and shift in addition to the prior trending by date and error type. On October 24, 2014, a data field was added to enable trending by wing/unit. To ensure all occurrences are properly reported, trended, and addressed, a report of all incidents for the period, using a quality database tracking system, will be reviewed monthly during the QA meeting and quarterly during the TCC Advisory Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445404	A. BUILDING_____ B. WING_____	10/02/2014

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F 493	Continued From page 138 (b)	F 493	The QA Committee meets monthly on the third Wednesday of the month at 11:30am and includes the TCC Administrator, TCC Medical Director, DON, CE, PCCs, Social Services Department representative, Registered Dietician (RD), Minimum Data Set (MDS) coordinator, and the Pharmacy Consultant. The purpose of the QA Committee is to provide general oversight for the quality of care at the facility (see exhibit 14). The TCC Advisory Committee meets quarterly on the Fourth Wednesday of the month at 7:00am and includes the TCC Administrator, TCC Medical Director, DON, CNO, CE, PCCs, Social Services Department representative, RD, MDS coordinator, the pharmacy Consultant, and 2 medical staff members (see exhibit 15).	

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F 493	Continued From page 138 gained through in-services conducted by the Director of Nursing regarding the changes and implementation of the facility's new transcription and verification procedures. 10. Verification through interview with the Administrator, Medical Director, Chief Nursing Officer, Risk Management Team, Director of Nursing, and Director of the Pharmacy Vendor of their participation in risk management meeting to address the system changes with medication administration, and involvement of all parties in ongoing quality assurance. 11. Verification through observation and interview with ward clerks and registered nurses the facility discontinued the process of entering physician orders electronically by the ward clerks. 12. Verification through observation faxed medication orders were reconciled in real time. 13. Verification by interview with the Director of Pharmacy Vendor the pharmacy consultant will reconcile new medication orders weekly. Non-compliance continues at an "F" level for monitoring the effectiveness of corrective actions and evaluation of monitoring by the Quality Assurance Committee. The facility is required to submit a plan of correction.	F 493	Continued From Page 138(c)	
F 501 SS=L	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.	F 501	F501 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The medication errors of residents #262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238 have been additionally reviewed by the Transitional Care Center (TCC) (facility)	10/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 501	Continued From page 139 This REQUIREMENT is not met as evidenced by: Based on review of review of the Medical Director Agreement Contract, medical record review, review of facility investigations, review of facility policy and procedures, and interview, the Medical Director of the facility failed to ensure medications were reconciled, transcribed, and administered to residents in a safe manner. The Medical Director's failure to address the systemic problems related to the processes for accurate medication administration resulted in medication errors and placed sixteen residents (#262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238) of twenty-four residents reviewed for medication errors in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death). The facility's failure was likely to place any resident who received medications at risk for Immediate Jeopardy. The Administrator, Medical Director, Chief Medical Officer/In House Legal Counsel, Chief Nursing Officer, and Director of Nursing were informed of the Immediate Jeopardy on September 30, 2014, at 4:00 p.m., in the conference room. The Immediate Jeopardy was effective February 12, 2014 through October 1, 2014. An extended survey was conducted on September 30, to October 2, 2014. The facility submitted an Acceptable Allegation of Compliance to the survey team on October 2,	F 501	Medical Director and Nursing Leadership Team (created October 7, 2014). The Nursing Leadership Team meets at 8:00am Monday through Friday and is attended by the TCC Administrator, Director of Nursing (DON), Patient Care Coordinators (PCCs), Clinical Educator (CE), and Medical Director at her discretion or as requested. The Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and Medical Director have attended daily to ensure the Nursing Leadership Meeting is accomplishing its function. During this meeting, a general review of occurrences including medication errors and ensuring appropriate notification has been completed is discussed (see exhibit 7). None of the residents suffered a prolonged or permanent condition from the noted medication errors. Each resident was discharged as indicated below: #262 to Blount Memorial Hospital on July 25, 2014. She was discharged from the hospital to a second skilled nursing facility from which she later was discharged to home in good condition. #457 to home on March 31, 2014 #453 to home with Home Health on March 24, 2014 #452 to home on February 21, 2014 #454 to home with Home Health on March 19, 2014 #455 to home with Home Health on April 12, 2014 #456 to an Intermediate Care facility on April 9, 2014 #279 to home with Home Health on May 8, 2014 #111 to home with Home Health on August 10, 2014 #398 to home with Home Health on August 7, 2014	

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F 501	Continued From page 140 2014. The survey team verified the actions taken by the facility removed the jeopardy on October 2, 2014. Noncompliance continues at the "F" level. The findings included: Review of the Medical Director Agreement contract signed and dated by the Medical Director on August 16, 2012, revealed, "...2. Responsibilities of Medical Director...b. Develop Policies and Procedures. Assist in developing, executing, and periodically reviewing facility's written policies and procedures, medical protocols and standing orders as requested by Hospital and/or Department Leadership...n. Participate in Quality Assessment and Performance Improvement Program. Actively participate in the facility's Performance Improvement program, including identifying best practices, evaluating patient care, evaluating indicators relating to improved outcomes and patient and family satisfaction, and creating clinical models of care both within facility..." Interview with the Medical Director on September 29, 2014, at 2:34 p.m., in the conference room, revealed the Medical Director was aware of a specific case of medication error in which a resident required physician intervention (#262). Further interview confirmed the Medical Director made specific recommendations related to the medication errors with resident #262. Continued interview confirmed the Medical Director was not aware of a pattern of medication errors which had occurred and was related to the transcription, verification, and 24 hour chart checks by the Night Shift Licensed Nurses. Further interview with the Medical Director confirmed the facility had identified a "systemic issue" related to the	F 501	#105 to home with Home Health on August 14, 2014 #197 to home with Home Health on August 8, 2014 #23 to home with Home Health on September 4, 2014 #411 to home on August 29, 2014 #238 to home on September 30, 2014 The TCC (facility) Medical Director determined for resident #188, after she performed additional review of the medical record, the medication dispensing system reports, and pharmacy records, that the resident did not receive Coumadin as documented by the nurse. The nurse entry was inaccurate. This staff member no longer works at TCC (facility). In complete review of chart, there was NO order for Coumadin 2 mg to be given to the resident. However, an electronic request was sent to pharmacy for Coumadin 2 mg. Pharmacy rejected the order due to admission order clarification for "hold Coumadin". They notified TCC (facility) of rejection of order. The pharmacy (which generates Coumadin orders per protocol) did not generate a Coumadin order for this resident. There was no Coumadin withdrawn from the medication dispensing system profile assigned to this resident. The resident was discharged home to Assisted Living with Hospice on April 11, 2014. The Medical Director has been present on site daily including weekends (with the exception of October 4, 17, and 18 during which she was available by phone) since the completion of the survey. The Medical Director has actively participated in the following: The Nursing Leadership Team (created October 6, 2014) which reviews all occurrences daily and the TCC Medication Error/Risk Team (created October 7, 2014) which reviews all occurrences weekly.	

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F 501	Continued From page 141 facility's use of a software program for order entry and medication administration which required intervention and re-education of specific employees, however had not made any specific recommendations to the facility to address the systemic failure in the facility's medication administration process. Refer to F157-L, F 281-L, F309-L, F333-L, F425-L, F428-L, F490-L, F493-L The Immediate Jeopardy was effective from February 12 through October 1, 2014, and was removed onsite on October 2, 2014. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the surveyors through review of documents, staff interviews, and observations conducted onsite on October 2, 2014. The surveyors verified the allegation of compliance by: 1. Review of the facility's in-service records to ensure nursing staff were educated regarding changes for medication administration which included the implementation of paper Medication Administration Records (MARs). Review included the facility's plan of action to ensure all nurses were educated on the new system before being allowed to work a shift (coordinated by the Director of Nursing), and the facility's plan for education for nurses who were not scheduled to work or who were on vacation or Family Medical Leave. 2. Verification of the new medication administration system by the facility which included discontinuation of the Electronic Medication Administration Record (EMAR) and implementation of paper Medication	F 501	The Nursing Leadership Team meets at 8:00am Monday through Friday and is attended by the TCC Administrator, DON, Patient Care Coordinators (PCCs), Clinical Educator (CE), and Medical Director at her discretion or as requested. During this meeting, a general review of occurrences including evaluation of medication errors and assurance of appropriate notification is completed. Weekend occurrences are reviewed on Monday. The TCC Medication Error/Risk Team meets every Monday at 1:30pm and includes the TCC Medical Director, TCC Administrator, (CMO), (CNO), Consultant Pharmacist, Hospital Associate Nurse Executive, TCC DON, TCC PCC, TCC CE, Hospital Risk Manager, and Hospital Quality Management Director. In addition to other responsibilities (see exhibit 13), the Medication Error Team/Risk Team reviews all medication occurrence reports (see exhibit 6), identifies negative trends from the analysis of data we enter in our medication error database, and reviews the Hospital Quality Management audit results weekly. The team will also discuss any Safety Hotline calls made concerning medication errors or medication administration processes at TCC. This Hotline is used to report conditions affecting clinical resident safety or quality of care issues including medication errors or concerns. Calls may be left anonymously or callers may leave contact information. The calls are transcribed by the Quality Management Department at the hospital and reviewed individually by the Hospital Risk Manager and the CMO. The Hospital Safety Hotline phone number is posted in staff work areas. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents in the TCC (facility) were considered to have the potential to be affected. The Electronic Medication Administration Record (E-MAR), Electronic Treatment Administration Record (E-TAR), and Electronic Physician Order Entry (E-POE) system was abandoned immediately on September 30, 2014, returning to a hand-written, paper-based MAR, TAR, and physician order system, effective October 1, 2014.	

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F 501	Continued From page 142 Administration Records. Verification included review reconciling new physician's orders and the correct reconciliation to the new paper MARs. 3. Verification through interview with the Director of Nursing and Medical Director, and review of facility documentation all current resident's medication orders were accurately transcribed to paper MARs. 4. Verification through interview with Director of Nursing and review of the Medication Occurrence Report modified to require the date and time of notification of resident and/or family of medication errors. 5. Verification through interview with the Administrator, and review of facility documentation the facility's identification of eight transcription errors during the facility's audit of all current resident's medication orders. Review of facility documentation verified residents or resident's family, and physician were notified of the errors. Verification through interview with the Medical Director of immediate intervention to assess resident's status after identification of the error, and provide clarification orders where needed. 6. Review of a random sample of active resident charts to verify the accurate transcription of new physician's orders to the paper MARs. Review of random sample of active resident charts for the completeness and accuracy of 24 hour chart checks. 7. Verification through observation in both nursing stations new orders were being transcribed by Registered Nurses only. 8. Verification through observation of 3 Licensed Practical Nurses (two on the ground floor and one on main floor) of medication administration by Licensed Practical Nurses with the addition of Registered Nurses assisting to ensure the	F 501	On September 30, 2014 through October 1, 2014, charts and MARs of 100% of the current residents (68) were reviewed during our conversion from electronic MAR to paper MAR. In the process, the records were analyzed for any medication errors by the Medical Director who was on site through the entire conversion process. Our initial review identified 7 residents (8 errors) who we thought were affected. However, on further review, one resident (MR# 425745) had previously been notified of the error and another (one of two on MR# 448221) was found not to be an error. The following residents were affected: Resident MR# 475365: Omission of medication on September 14, 2014. Resident MR# 483234: Transcription error on September 18, 2014. Resident MR# 689434: Transcription error on September 25, 2014. Resident MR# 791005: Transcription error on September 23, 2014. Resident: MR# 524029: Transcription error on September 4, 2014. Resident MR# 448221: Transcription error on September 15, 2014. Starting September 30, 2014, additional Registered Nurses (RNs), employed by Parent Hospital (Blount Memorial) were assigned to the TCC to complete the following tasks (see bullets). The Medical Director oversaw this process and clarified any questions concerning physician orders that were identified during the transcription process: • Transcribe all physician orders for every current resident to a hand-written MAR and/or TAR on September 30, 2014 for immediate use. • Two RNs verify accuracy of all physician orders for every current resident to a hand-written MAR and/or TAR after transcription completed on October 1, 2014. Continued On Page 143(a)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 501	Continued From page 143	F 501	• Provide every 12 hour chart checks to include review of all MARs, TARs, and new physician orders effective October 1, 2014. This process is ongoing. • Administer all medications under the purview of two licensed nurses (RN or Licensed Practical Nurse (LPN)) effective October 1, 2014. This process is ongoing. The TCC Medication Error/Risk Team, inclusive of the TCC Medical Director, TCC Administrator, Hospital CMO, Hospital CNO, Consultant Pharmacist, Hospital Associate Nurse Executive, TCC Director of Nursing (DON), TCC Patient Care Coordinator (PCC), TCC Clinical Educator (CE), Hospital Risk Manager, and Hospital Quality Management Director review all occurrences weekly. The CMO, CNO, Hospital Director of Quality Management, and the Hospital Risk Manager also serve on the Hospital Risk Team, which also meets weekly. In addition, the CMO serves as Chairman for the TCC Medication Error/Risk Team and will provide a summary of issues monthly for the Governing Board (Blount Memorial Hospital Board of Directors) as indicated. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; The Medical Director has been present on site daily including weekends (with the exception of October 4, 17, and 18 during which she was available by phone) since the completion of the survey. The following actions have been taken by the Medical Director since September 30, 2014. This is not all inclusive of her involvement thus far, but addresses key responsibilities and functions of the Medical Director that will continue moving forward: Policy Formation and Revision	

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F 501	Continued From page 143(a)	F 501	The Medical Director reviewed and approved the following new policies or policy revisions: "Change in a Resident's Condition or Status" (see exhibit 2), "Medication Occurrence: Procedure for Reporting" (see exhibit 3), "Medication Administration" (see exhibit 17), "Identifying and Maintaining an Adequate Weight for all Patients Considered High Risk for Weight Loss" (see exhibit 23), and "Abuse Investigation and Reporting" (see exhibit 8). Improvement of Quality of Care and Services Participated in formation of the process, policy and implementation of a safe process for transcription of medication orders. Participation in the process of converting all electronic MARs to paper MARs on September 30, 2014 including clarification of medication orders. Participation in Committees providing guidance and oversight of care including Nursing Leadership Meetings, TCC Medication Error/ Risk Management Team, QA Committee, and Weight Team Meeting. The Medical Director has also participated in several informal meetings with Nursing leadership, the Administrator, Hospital Leadership, and the Director of the consulting pharmacy to discuss process improvement. Communicated with all Attending Physicians to relay the findings of the survey, changes in the medication transcription, verification, and administration processes, education on their responsibilities to residents in the facility, and addressed any related questions or concerns. Source of education, training, and information Educated the dieticians on the policies "Change in a Resident's Condition or Status" (see exhibit 2) and "Identifying and Maintaining an Adequate Weight for all Patients Considered High Risk for Weight Loss (see exhibit 23)"	

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F 501	Continued From page 143(b)	F 501	Educated nursing staff on communication with physicians, medication errors, routine and urgent medications, medication administration, high risk medications, order verification and charting (see exhibit 19). The Medical Director continues to attend to residents, participate in process improvement projects, and ensure the health and well-being of all residents in the facility as expected. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. The expectation has been set by the CMO, CNO, and Administrator for the Medical Director to attend, actively participate, and contribute to the above referenced teams and boards. Documentation of the involvement of the Medical Director will be maintained.	

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F 501	Continued From page 143 accuracy of administered medications. 9. Verification through interviews with nine Registered Nurses, seven Licensed Practical Nurses, and three Ward Clerks/Certified Nursing Assistants to determine the comprehension gained through in-services conducted by the Director of Nursing regarding the changes and implementation of the facility's new transcription and verification procedures. 10. Verification through interview with the Administrator, Medical Director, Chief Nursing Officer, Risk Management Team, Director of Nursing, and Director of the Pharmacy Vendor of their participation in risk management meeting to address the system changes with medication administration, and involvement of all parties in ongoing quality assurance. 11. Verification through observation and interview with ward clerks and registered nurses the facility discontinued the process of entering physician orders electronically by the ward clerks. 12. Verification through observation faxed medication orders were reconciled in real time. 13. Verification by interview with the Director of Pharmacy Vendor the pharmacy consultant will reconcile new medication orders weekly. Non-compliance continues at an "F" level for monitoring the effectiveness of corrective actions and evaluation of monitoring by the Quality Assurance Committee. The facility is required to submit a plan of correction.	F 501	Continued From Page 143(c)	
F 520 SS=L	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520	F520 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	10/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 144 assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigations, review of facility policies and procedures, and interview, the facility failed to maintain an effective Quality Assurance Program which identified and addressed the systemic failures of inaccurate medication transcription, verification of physician orders for medication, and 24 hour chart checks by licensed nurses to ensure medication orders were followed. The failure resulted in medication errors and placed sixteen residents (#262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238) of twenty-four residents reviewed for medication errors in Immediate	F 520	The medication errors of residents #262, #457, #188, #453, #452, #454, #455, #456, #279, #111, #398, #105, #197, #23, #411, #238 have been additionally reviewed by the Transitional Care Center (TCC) (facility) Medical Director and Nursing Leadership Team (created October 7, 2014). The Nursing Leadership Team meets at 8:00am Monday through Friday and is attended by the TCC Administrator, Director of Nursing (DON), Patient Care Coordinators (PCCs), Clinical Educator (CE), and Medical Director at her discretion or as requested. The Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and Medical Director have attended daily to ensure the Nursing Leadership Meeting is accomplishing its function. During this meeting, a general review of occurrences including medication errors and ensuring appropriate notification has been completed is discussed (see exhibit 7). None of the residents suffered a prolonged or permanent condition from the noted medication errors. Each resident was discharged as indicated below: #262 to Blount Memorial Hospital on July 25, 2014. She was discharged from the hospital to a second skilled nursing facility from which she later was discharged to home in good condition. #457 to home on March 31, 2014 #453 to home with Home Health on March 24, 2014 #452 to home on February 21, 2014 #454 to home with Home Health on March 19, 2014 #455 to home with Home Health on April 12, 2014 #456 to an Intermediate Care facility on April 9, 2014 #279 to home with Home Health on May 8, 2014 #111 to home with Home Health on August 10, 2014	

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F 520	Continued From page 145 Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death). The facility's failure was likely to place any resident who received medications at risk for Immediate Jeopardy. The Administrator, Medical Director, Chief Medical Officer/In House Legal Counsel, Chief Nursing Officer, and Director of Nursing were informed of the Immediate Jeopardy on September 30, 2014, at 4:00 p.m., in the conference room. The Immediate Jeopardy was effective February 12, 2014 through October 1, 2014. An extended survey was conducted on September 30, to October 2, 2014. The facility submitted an Acceptable Allegation of Compliance to the survey team on October 2, 2014. The survey team verified the actions taken by the facility removed the jeopardy on October 2, 2014. Noncompliance continues at the "F" level. The findings included: Interview with the Clinical Educator/Quality Assurance (CE/QA) Nurse on September 30, 2014, at 8:37 a.m., in the conference room, revealed the CE/QA Nurse was responsible for the review of medication errors and was responsible for reporting the errors to the Continuous Quality Improvement Committee (CQI). Continued interview with the CE/QA Nurse revealed the CE/QA nurse only conducted a root-cause analysis of medication errors "...if it	F 520	#398 to home with Home Health on August 7, 2014 #105 to home with Home Health on August 14, 2014 #197 to home with Home Health on August 8, 2014 #23 to home with Home Health on September 4, 2014 #411 to home on August 29, 2014 #238 to home on September 30, 2014 The TCC (facility) Medical Director determined for resident #188, after she performed additional review of the medical record, the medication dispensing system reports, and pharmacy records, that the resident did not receive Coumadin as documented by the nurse. The nurse entry was inaccurate. This staff member no longer works at TCC (facility). In complete review of chart, there was NO order for Coumadin 2 mg to be given to the resident. However, an electronic request was sent to pharmacy for Coumadin 2 mg. Pharmacy rejected the order due to admission order clarification for "hold Coumadin". They notified TCC (facility) of rejection of order. The pharmacy (which generates Coumadin orders per protocol) did not generate a Coumadin order for this resident. There was no Coumadin withdrawn from the medication dispensing system profile assigned to this resident. The resident was discharged home to Assisted Living with Hospice on April 11, 2014. The summary of occurrences was presented at the monthly Transitional Care Center (TCC) Quality Assurance (QA) committee. This committee meets monthly on the third Wednesday of the month at 11:30am and includes the TCC Administrator, TCC Medical Director, Director of Nursing (DON), Clinical Educator (CE), Patient Care Coordinators (PCCs), Social Services Department representative, Registered Dietician (RD), Minimum Data Set (MDS) coordinator, and the Pharmacy Consultant. The purpose of the QA Committee is to provide general oversight for the quality of care at the facility (see exhibit 14).	

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F 520	Continued From page 146 was something really complicated..." Interview with the Administrator on September 30, 2014, at 10:13 a.m., in the conference room, confirmed the Administrator was the chair of the CQI committee, and had oversight of quality assurance of the facility. Continued interview with the Administrator confirmed the Administrator had been aware of medication errors which had occurred in the facility, and confirmed medication errors were discussed in CQI meetings. Continued interview with the Administrator confirmed the number of medication errors which occurred in the facility was reported during each CQI meeting. Further interview with the Administrator revealed the CQI team had identified an issue with the computer software program which the facility utilized for entering orders and for medication administration. Further interview confirmed the facility "...did one update..." to the software to address problems identified. Further interview confirmed the Administrator was aware of continued medication errors in the facility. The Administrator stated, "...don't look at all of them..." Continued interview confirmed the Director of Nursing was responsible for the communication to the CQI committee regarding medication errors, "...did not discuss every single one..." Further interview with the Administrator revealed the CQI committee did not identify a breakdown in the process of medication administration "...felt like more individualized (focused on specific staff members that made transcription or verification mistakes)..." Continued interview confirmed the Administrator and CQI committee "...do not have a clear answer..." to address the systemic problems with medication administration in the facility. The Administrator stated, "...I don't	F 520	How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents in the TCC (facility) were considered to have the potential to be affected. The Electronic Medication Administration Record (E-MAR), Electronic Treatment Administration Record (E-TAR), and Electronic Physician Order Entry (E-POE) system was abandoned immediately on Septemeber 30, 2014, returning to a hand-written, paper-based MAR, TAR, and physician order system, effective October 1, 2014. On September 30, 2014 through October 1, 2014, charts and MARs of 100% of the current residents (68) were reviewed during our conversion from electronic MAR to paper MAR. In the process, the records were analyzed for any medication errors by the Medical Director who was on site through the entire conversion process. Our initial review identified 7 residents (8 errors) who we thought were affected. However, on further review, one resident (MR# 425745) had previously been notified of the error and another (one of two on MR# 448221) was found not to be an error. The following residents were affected: Resident MR# 475365: Omission of medication on September 14, 2014. Resident MR# 483234: Transcription error on September 18, 2014. Resident MR# 689434: Transcription error on September 25, 2014. Resident MR# 791005: Transcription error on September 23, 2014. Resident: MR# 524029: Transcription error on September 4, 2014. Resident MR# 448221: Transcription error on September 15, 2014. Starting September 30, 2014, additional Registered Nurses (RNs), employed by Parent Hospital (Blount Memorial) were assigned to the TCC to complete the following tasks (see bullets).	

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F 520	Continued From page 147 know...I'm just speculating where I think the problem is..." Interview with the CE/QA Nurse on September 30, 2014, at 10:45 a.m., in the conference room, revealed the CQI committee had discussed specific medication errors which had occurred and had been sent to the Risk Management Team. Continued interview revealed had identified a trend related to the new employee education process, and trends related to specific employees with transcription errors which "...required retraining (on an individual basis)..." Further interview revealed the CE/QA Nurse had identified, in the process of 24 hour chart checks, the same nurse completing order verification was the same nurse which was completing the 24 hour chart checks, and had discussed with the Director of Nursing a plan to include Licensed Practical Nurses (LPNs) in the completion of the 24 hour chart checks. Continued interview confirmed LPNs were educated in the completion of 24 hour chart checks. Continued interview confirmed neither the CE/QA Nurse nor the Director of Nursing (DON) monitored the addition of the LPNs. Further interview with the CE/QA Nurse confirmed the CE/QA Nurse regularly attended CQI meetings and was present during Quarterly Advisory meetings. Continued interview revealed the CE/QA Nurse was asked by the Medical Director of the facility "...to look at process..." Further interview confirmed "...identified that the process of med [medication] entry by ward clerks was being interrupted..." and the intervention initiated by the CE/QA Nurse was to inform the ward clerks to no longer take charts to another floor during the completion of medication entry in the computer. Continued interview with the CE/QA Nurse revealed the	F 520	The Medical Director oversaw this process and clarified any questions concerning physician orders that were identified during the transcription process: • Transcribe all physician orders for every current resident to a hand-written MAR and/or TAR on September 30, 2014 for immediate use. • Two RNs verify accuracy of all physician orders for every current resident to a hand-written MAR and/or TAR after transcription completed on October 1, 2014. • Provide every 12 hour chart checks to include review of all MARs, TARs, and new physician orders effective October 1, 2014. This process is ongoing. • Administer all medications under the purview of two licensed nurses (RN or Licensed Practical Nurse (LPN)) effective October 1, 2014. This process is ongoing. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; The TCC Medication Error/Risk Team (see exhibit 13), which began meeting on October 6, 2014 and includes the TCC Medical Director, TCC Administrator, Hospital CMO, Hospital CNO, Consultant Pharmacist, Hospital Associate Nurse Executive, TCC DON, TCC PCCs, TCC CE, Hospital Risk Manager, and Hospital Quality Management Director reviews all occurrences weekly. The CMO, CNO, Hospital Director of Quality Management, and the Hospital Risk Manager also serve on the Hospital Risk Team, which also meets weekly. The TCC Medication Error/Risk Team functions as an independent committee reporting its findings to the parent hospital and the QA committee to enhance its ability to better identify negative patterns or trends involving any adverse occurrence The CMO serves as Chairman of the TCC Medication Error/Risk Team and will provide a summary of issues monthly for the Governing Board (Blount Memorial Hospital Board of Directors) as indicated.	

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F 520	Continued From page 148 ward clerks were also instructed to complete order entry "...in the back..." of the nurse station, "...probably biggest thing I've seen..." (for addressing medication errors). Further interview confirmed the only significant intervention put in place by the facility was the instruction provided to the ward clerks by the CE/QA Nurse, and the facility failed to identify a continued pattern of medication and transcription errors. Refer to F157-L, F281-L, F309-L, F333-L, F425-L, F428-L, F490-L, F493-L, F501-L The Immediate Jeopardy was effective from February 12 through October 1, 2014, and was removed onsite on October 2, 2014. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the surveyors through review of documents, staff interviews, and observations conducted onsite on October 2, 2014. The surveyors verified the allegation of compliance by: 1. Review of the facility's in-service records to ensure nursing staff were educated regarding changes for medication administration which included the implementation of paper Medication Administration Records (MARs). Review included the facility's plan of action to ensure all nurses were educated on the new system before being allowed to work a shift (coordinated by the Director of Nursing), and the facility's plan for education for nurses who were not scheduled to work or who were on vacation or Family Medical Leave. 2. Verification of the new medication administration system by the facility which included discontinuation of the Electronic	F 520	Initial education on the transcription and verification process (see exhibit 16) was completed by the CNO on September 30, 2014 during a face to face educational session with all RNs and LPNs present that shift. For the subsequent shifts on September 30, 2014 and October 1, 2014, the DON reviewed the Allegation of Compliance and the process for transcribing and verifying MARs and TARs, chart check process, and new medication occurrence report, with each shift's RNs and LPNs (see exhibit 16). From October 1, 2014 through October 16, 2014 The TCC Medical Director, CNO, Interim DON, Interim CE, and Clinical Director of the contract pharmacy developed a process for utilizing a printed MAR established by the pharmacy. This process is outlined in the "Medication Administration" policy (see exhibit 17). This is a new policy that was created by the Associate Nurse Executive of the parent hospital on and approved on October 22, 2014 by the Interim DON, CNO, and Medical Director. This policy describes the transcription and verification process and was implemented October 25, 2014. Educational in-service (see exhibit 4) on the "Medication Administration" policy was conducted by Interim DON, Interim CE, and Patient Care Coordinators (PCCs) from October 22, 2014 through October 25, 2014, and included all registered nurses (RNs), licensed practical nurses (LPNs), certified nurse assistants (CNAs) and ward clerks (WCs). Two staff members were on vacation during this in-service and completed their education to this policy by October 27, 2014 (see exhibit 5). New or contract staff will receive education to this policy (see exhibit 17) as part of their new employee orientation packet. This educational material will be updated as policy changes occur by the CE. The CE will also be responsible for educating current RNs, LPNs, CNAs, and WCs of policy changes when they occur. Beginning October 17, 2014, TCC (facility) receives a printed MAR from the pharmacy every day for the next 24 hour period. These MARs are reviewed by two RNs for accuracy prior to use for medication pass by TCC (facility) nurses.	

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F 520	Continued From page 149 Medication Administration Record (EMAR) and implementation of paper Medication Administration Records. Verification included review reconciling new physician's orders and the correct reconciliation to the new paper MARs. 3. Verification through interview with the Director of Nursing and Medical Director, and review of facility documentation all current resident's medication orders were accurately transcribed to paper MARs. 4. Verification through interview with Director of Nursing and review of the Medication Occurrence Report modified to require the date and time of notification of resident and/or family of medication errors. 5. Verification through interview with the Administrator, and review of facility documentation the facility's identification of eight transcription errors during the facility's audit of all current resident's medication orders. Review of facility documentation verified residents or resident's family, and physician were notified of the errors. Verification through interview with the Medical Director of immediate intervention to assess resident's status after identification of the error, and provide clarification orders where needed. 6. Review of a random sample of active resident charts to verify the accurate transcription of new physician's orders to the paper MARs. Review of random sample of active resident charts for the completeness and accuracy of 24 hour chart checks. 7. Verification through observation in both nursing stations new orders were being transcribed by Registered Nurses only. 8. Verification through observation of 3 Licensed Practical Nurses (two on the ground floor and one on main floor) of medication administration by	F 520	The Nursing Leadership Team reviews all occurrences daily and the TCC Medication Error/Risk Team reviews all occurrences weekly. The Nursing Leadership Meeting meets at 8:00am Monday through Friday and is attended by the TCC Administrator, DON, Patient Care Coordinators (PCCs), CE, and Medical Director at her discretion or as requested. During this meeting, a general review of occurrences including medication errors and ensuring appropriate notification has been completed. (see exhibit 7). Weekend occurrences are reviewed on Monday. The TCC Medication Error/Risk Team meets every Monday at 1:30pm and includes the TCC Medical Director, TCC Administrator, Hospital CMO, Hospital CNO, Consultant Pharmacist, Hospital Associate Nurse Executive, TCC DON, TCC PCC, TCC CE, Hospital Risk Manager, and Hospital Quality Management Director. In addition to other responsibilities (see exhibit 13), the Medication Error Team/Risk Team reviews all medication occurrence reports (see exhibit 6), identifies negative trends from the analysis of data we enter in our medication error database, and reviews the Hospital Quality Management audit results weekly. The TCC Medication Error/Risk Team functions as an independent committee reporting its findings to the parent hospital and the Quality Assurance (QA) Committee to enhance its ability to better identify negative patterns or trends involving any adverse occurrence. Identification of trends will enhance the QA Committee's effectiveness. The team will also discuss any Safety Hotline calls made concerning medication errors or medication administration processes at TCC. This Hotline is used to report conditions affecting clinical resident safety or quality of care issues including medication errors or concerns. Calls may be left anonymously or callers may leave contact information. The calls are transcribed by the Quality Management Department at the hospital and reviewed individually by the Hospital Risk Manager and the Chief Medical Officer. The Hospital Safety Hotline phone number is posted in staff work areas.	

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F 520	Continued From page 150 Licensed Practical Nurses with the addition of Registered Nurses assisting to ensure the accuracy of administered medications. 9. Verification through interviews with nine Registered Nurses, seven Licensed Practical Nurses, and three Ward Clerks/Certified Nursing Assistants to determine the comprehension gained through in-services conducted by the Director of Nursing regarding the changes and implementation of the facility's new transcription and verification procedures. 10. Verification through interview with the Administrator, Medical Director, Chief Nursing Officer, Risk Management Team, Director of Nursing, and Director of the Pharmacy Vendor of their participation in risk management meeting to address the system changes with medication administration, and involvement of all parties in ongoing quality assurance. 11. Verification through observation and interview with ward clerks and registered nurses the facility discontinued the process of entering physician orders electronically by the ward clerks. 12. Verification through observation faxed medication orders were reconciled in real time. 13. Verification by interview with the Director of Pharmacy Vendor the pharmacy consultant will reconcile new medication orders weekly. Non-compliance continues at an "F" level for monitoring the effectiveness of corrective actions and evaluation of monitoring by the Quality Assurance Committee. The facility is required to submit a plan of correction.	F 520	How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. On October 16, 2014, additional data fields were added to the occurrence tracking system that enable trending of medication error details by employee and shift in addition to the prior trending by date and error type. October 24, 2014, a data field was added to enable trending by wing/unit. To ensure all occurrences are properly reported, trended, and addressed, a report of all incidents for the period, using a quality database tracking system, will be reviewed monthly during the QA meeting and quarterly during the TCC Advisory Committee meeting. The QA Committee meets monthly on the third Wednesday of the month at 11:30am and includes the TCC Administrator, TCC Medical Director, DON, CE, PCCs, Social Services Department representative, Registered Dietician (RD), Minimum Data Set (MDS) coordinator, and the Pharmacy Consultant. The purpose of the QA Committee is to provide general oversight for the quality of care at the facility (see exhibit 14). The TCC Advisory Committee meets quarterly on the Fourth Wednesday of the month following the end of the quarter at 7:00am and includes the TCC Administrator, TCC Medical Director, Director of Nursing, Chief Nursing Officer, Clinical Educator, Patient Care Coordinators, Social Services representative, Registered Dietician, Minimum Data Set (MDS) coordinator, the Pharmacy Consultant, and 2 medical staff members (see exhibit 15). Starting October 15, 2014, all QA Committee agendas and minutes will be reviewed by the Hospital Quality Management Director monthly for 3 months, then quarterly on an ongoing basis. If indicated, the Hospital Quality Management Director will make recommendations to the CNO and TCC (facility) Administrator. The Hospital Director of Quality Management reports directly to the CMO.	